DOCUMENT RESUME

ED 398 212 SP 036 841

AUTHOR Bensley, Loren B., Ed.; Drolet, Judy C., Ed.
TITLE Graduate Professional Preparation in Health Education.
INSTITUTION Eta Sigma Gamma, Muncie, Ind.
PUB DATE Dec 95
NOTE 177p.; Eta Sigma Gamma Monograph Series, v13 n2 December 1995.
AVAILABLE FROM Eta Sigma Gamma, 2000 University Avenue, Muncie, IN 47306.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC08 Plus Postage.
DESCRIPTORS Graduate Students; *Graduate Study; Guidelines; *Health Education; *Health Personnel; Higher Education; Medical Education; *Professional Education; *State Standards; Teacher Competencies; *Teacher Education Programs
IDENTIFIERS *Health Educators

ABSTRACT

This monograph presents selected perspectives on the status of graduate studies in health education and related issues of interest to graduate students and the professionals who prepare them. The publication is in 13 chapters: (1) "Graduate Education in Health Education: Keeping Perspective, Building Momentum" (A. C. Henderson); (2) "The Evolving Graduate Programs in Health Education" (W. H. Creswell, Jr. and A. E. Nolte); (3) "Overview of the Development of Graduate Health Education Standards" (Joint Committee for the Development of Graduate Level Preparation Standards); (4) "A Case Study in Developing State Guidelines for Preparing Undergraduate and Graduate Health Educators" (W. B. Cissell); (5) "Empowering Health Educators to Integrate Competencies into Graduate Course Syllabi" (J. C. Drolet, E. Ames, and J. V. Fetro); (6) "Selecting a Graduate Health Education Program to Meet Your Needs" (M. R. Torabi); (7) "Health Education Theory: A Foundation for Graduate Education" (K. Welshimer); (8) "Ethical Dilemmas in Relationships between Professors and Students in Graduate Education" (T. P. Hardman); (9) "Graduate Preparation in Ph. D. Programs: Securing a Position in Higher Education" (S. M. Patterson); (10) "Preparing Health Educators for Academic Medicine: The Health Care Reform Opportunity" (J. J. Neutens); (11) "Being a T.A.: Balancing Being a Pro and a Student" (O. Grosshans and J. Brookins-Fisher); (12) "Turning Course Assignments and Projects into Professional Contributions" (R. J. Bensley); (13) "Graduate Programs in the Year 2020" (G. E. Richardson). (ND)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

The Eta Sigma Gamma

Monograph Series

PERMISSION TO REPRODUCE AND
DISSEMINATE THIS MATERIAL
HAS BEEN GRANTED BY

M Torabi

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)

ED 398 212

GRADUATE PROFESSIONAL PREPARATION IN HEALTH EDUCATION

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

VOLUME 13 NUMBER 2
DECEMBER 1995

Published by Eta Sigma Gamma
National Professional Health Education Honorary

SP036841

BEST COPY AVAILABLE

Volume 13 Number 2
December 1995

The Eta Sigma Gamma

Monograph Series

Guest Editors
For This Issue
Loren B. Bensley, Ed.D.
Professor
Department of Health Promotion and Rehabilitation
Central Michigan University
Mt. Pleasant, Michigan 47304

Judy C. Drolet, Ph.D., CHES, FASHA
Professor
Department of Health Education and Recreation
Southern Illinois University
Carbondale, IL 62901-2430

Editor
Monograph Series
Mohammad R. Torabi, Ph.D., M.P.H., CHES
Professor and Assistant Chair
Department of Applied Health Science
Indiana University
Bloomington, Indiana 47405

Eta Sigma Gamma wishes to gratefully acknowledge the John P. McGovern Foundation for its generosity in helping to make this monograph series possible.

The Eta Sigma Gamma Monograph Series is published by Eta Sigma Gamma, the National Professional Health Education Honorary, 2000 University Avenue, Muncie, Indiana 47306. A non-profit organization, Eta Sigma Gamma is dedicated to the elevation of standards, ideals, competence, and ethics of professionally trained men and women in the Health Science discipline. Third class, bulk-rate postage paid at Muncie, Indiana.

GRADUATE PROFESSIONAL PREPARATION IN HEALTH EDUCATION

VOLUME 13 NUMBER 2
DECEMBER 1995

Published by Eta Sigma Gamma
National Professional Health Education Honorary

NATIONAL EXECUTIVE COMMITTEE
ETA SIGMA GAMMA

Dr. Kelli McCormack-Brown
(President)
Dept. of Health Sciences
Illinois State University
Bloomington, IL 61761-6901
Office - (309) 438-8329
FAX - (309) 438-2450

Dr. Beverly Mahoney
(Vice-President)
Dept. of Health Education
The Pennsylvania State University
1 White Bldg.
University Park, PA 16802
Office - (814) 863-0435

Dr. Steve Dorman
(Immediate Vice-President)
Dept. of Health Science Ed.
University of Florida
FLG-5
Gainesville, FL 32611
Office - (904) 392-0583
FAX - (904) 392-3186

Dr. James McKenzie
(Secretary-Treasurer)
Dept. of Physiology and
Health Science
2000 W. University Avenue
Ball State University
Muncie, IN 47306
Office - (317) 285-5961
FAX - (317) 285-2351

Dr. Mohammad R. Torabi
(Editor -*Monograph Series*)
Dept. of Applied Health Science
Indiana University, HPER 116
Bloomington, IN 47405
Office - (812) 855-4808
FAX - (812) 855-3936

Dr. Judith Luebke
(Editor - *Health Educator*)
Dept. of Health Science
Mankato State University
Mankato, MN 56002
Office - (507) 389-1527

Dr. Roberta J. Ogletree
(At Large)
Dept. of Health Education
Southern Illinois University
Carbondale, IL 62901
Office - (618) 453-2777

Dr. Robert Bensley
(At Large)
Dept. of HPER
4024 Gary Center
Western Michigan University
Kalamazoo, MI 49008-3871
Office - (616) 387-3081

Ms. Jodi Brookins-Fisher
(Student Representative)
622 East Wilson
Salt Lake City, UT 84105
Home - (801) 486-8217

Dr. Loren Bensley, Jr.
(Historian)
Dept. of Health Education
Central Michigan University
Mt. Pleasant, MI 48858
Office - (517) 774-3392
Home - (616) 386-5812

Ms. Donna Ganion
(Executive Director)
Ms. Meg Wood
(Director of Publications)
Eta Sigma Gamma National Office
2000 W. University Avenue
Muncie, IN 47306
Office - (317) 285-2258
FAX - (317) 285-2351

FOREWORD

Graduate education in health education is at a turning point. What guidance will it receive from its heritage? What direction for its present? What vision for its future?

The profession has always set standards for graduate professional preparation. The Pere Marquette conference in 1950, the Washington, D.C. conference in 1967, and the attempt by SOPHE in 1977 to establish guidelines at the masters degree level are examples of events that helped shape graduate education. New graduate programs during this time were implemented in order to meet the need to develop and coordinate community and school health programs. An additional need was to prepare individuals for positions in higher education. Over the past 20 years, little attention has been paid to graduate standards or program quality. These editors believe that the time is right for healthy discussion and constructive commentary that will contribute to better prepared, qualified graduate students.

Through undergraduate and graduate education we create learning opportunities that challenge and stretch what we know, what we do, and how we apply knowledge and skills. This monograph is an attempt to stimulate thinking and examination of the present and future of graduate health education programs among graduate students and their professors.

The purpose of this monograph is to present selected perspectives on the status of graduate studies in health education and to provide a dialogue on related issues of interest to graduate students and professionals who prepare them. The selection of content is varied and addresses teaching, standards, issues and challenges, program "ingredients," background, as well as future visions, of the profession.

Authors were invited to submit papers on topics identified by the co-authors. Selection of these writers was based on their expertise and professional reputation.

The co-editors wish to thank these authors for their contributions and cooperation in making this monograph a reality. Their knowledge, experience, creativity, and insights will balance our thinking and guide future directions of graduate programs in health education.

As a final note, we wish to dedicate this issue of the Monograph to the present and future graduate students of our profession. May they strive to achieve the principles of Eta Sigma Gamma which are: teaching, service, and research.

Loren B. Bensley, Jr, Ed.D.
Mt. Pleasant, Michigan

Judy C. Drolet, Ph.D., CHES, FASHA
Carbondale, Illinois

PREFACE

On behalf of our National Executive Committee of **Eta Sigma Gamma**, I would like to offer my special thanks to the guest editors, Dr. Loren B. Bensley and Dr. Judy C. Drolet who worked very hard in making an important contribution to our field.

This issue deals with timely topics on graduate education which are the heart and soul of our past, present, and future success of our profession. Preparing our future scholars, educators, and leaders, to a great extent, depends on recruiting committed students to the field and providing quality learning opportunities. Eta Sigma Gamma, the National Professional Health Service Honorary, is proud to devote this issue to the graduate in health education professional preparation.

I would also like to thank Ms. Terri King for her assistance in preparing the publication and Ms. Joyce Arthur for her technical assistance. Last, but not least, I would like to offer my appreciation to each and every member of the National Executive Committee who are very committed in supporting these monograph series.

Finally, thank you for sharing your comments with me regarding the past Monograph Series. As always, I am eager to hear your criticisms, comments, and suggestions regarding these publications. Your input is essential in improving the publication and ultimately serving our members and the profession in the most effective way. It is a privilege for me to serve the Eta Sigma Gamma members and our profession.

I look forward to hearing from you.

Mohammad R. Torabi, PhD, MPH, CHES
Editor, **Monograph Series**
Indiana University

CONTENTS

FOREWORD iii
PREFACE vii

CHAPTER 1
"Graduate Education in Health Education: Keeping Perspective, Building Momentum"
Alan C. Henderson 1

CHAPTER 2
"The Evolving Graduate Programs in Health Education"
William H. Creswell, Jr.
Anne E. Nolte 16

CHAPTER 3
"Overview of the Development of Graduate Health Education Standards"
Joint Committee for the Development of Graduate Level Preparation Standards 36

CHAPTER 4
"A Case Study in Developing State Guidelines for Preparing Undergraduate and Graduate Health Educators"
William B. Cissell 44

CHAPTER 5
"Empowering Health Educators to Integrate Competencies into Graduate Course Syllabi"
Judy C. Drolet
Evelyn Ames
Joyce V. Fetro 53

CHAPTER 6
"Selecting a Graduate Health Education Program to Meet Your Needs"
Mohammad R. Torabi 67

CHAPTER 7
"Health Education Theory: A Foundation for Graduate Education"
Kathleen Welshimer 79

CONTENTS

CHAPTER 8
"Ethical Dilemmas in Relationships Between Professors and Students in Graduate Education"
Teresa Pennington Hardman 89

CHAPTER 9
"Graduate Preparation in Ph.D. Programs: Securing a Position in Higher Education"
Sheila M. Patterson 98

CHAPTER 10
"Preparing Health Educators for Academic Medicine: The Health Care Reform Opportunity"
James J. Neutens 113

CHAPTER 11
"Being a T.A.: Balancing Being a Pro and a Student"
Onie Grosshans
Jodi Brookins-Fisher 125

CHAPTER 12
"Turning Course Assignments and Projects into Profession Contributions"
Robert J. Bensley 133

CHAPTER 13
"Graduate Programs in the Year 2020"
Glenn E. Richardson 142

CONTRIBUTORS 165

CHAPTER 1

GRADUATE EDUCATION IN HEALTH EDUCATION: KEEPING PERSPECTIVE, BUILDING MOMENTUM

Alan C. Henderson, Dr. PH, CHES

Health education has come into its own as a profession and a discipline in the 1990s as society has increasingly turned its attention to behavioral contributions to health status and longevity. The discipline has increased and extended its capacity to plan, develop, implement and evaluate programs to promote health and prevent disease through professional preparation programs, health education practice, and research. Since the 1970s, health education has had a role at the federal level in policy and program development. Much has been accomplished, yet much remains to be done. These advances have been due, to a great extent, to the ability of professional preparation programs to educate, graduate, and place health education practitioners, researchers, and policy makers in key positions and roles in local, state, national, and international settings. Within professional preparation, graduate education plays a pivotal role in selecting and developing leaders in practice, policy -making, professional, organizational, and research settings.

Foundation Factors

Aside from substantial societal shifts toward examining lifestyles and health, there are at least five distinctive features encompassed by graduate education that have shaped the way health education has developed. The first is the underlying assumptions and values, attitudes, and beliefs that form the basis for health education as a profession. The second foundation factor

is the scientific base derived from applications of advances in the biomedical and behavioral sciences. The third foundation is the increasing technological capacity available to plan, develop, implement, and evaluate programs to specific target audiences in specific settings as well as technologies adapted to conducting health education research. As a fourth foundation factor, health educators have had to learn to collaborate with other professionals and other in their practice settings in recognition of the reciprocal nature of change in organizations, among target clientele, and the indirect and direct effects of social change. Finally, health educators have had to assume leadership positions in their employing organizations, policy-making organizations, and in their professional organizations to shape the direction of the field as well as to meet the challenges of a rapidly changing social environment.

Graduate education differs from undergraduate preparation in several important ways. First, advanced preparation necessitates narrow and deep study of health education in the context of its historical antecedents and contemporary society. The result of this focused preparation is a broadened perspective of the contributions of health education to society and narrowing attention to the substantial knowledge and skill base essential for successful health education practice and leadership. Second, graduate education refines and extends undergraduate preparation . For many, graduate education in health education is the only preparation received. Graduate education may represent a significant change in direction for a new graduate student, or it may represent an augmentation of another career in a different field. Third, graduate education requires a distinctively different orientation from undergraduate experiences. Graduate preparation has heightened emphases on cognitive skills, the ability to integrate seemingly unrelated factors, act as an advocate, and provide leadership in the field. Because of its focused, intensive nature and the need for developing future leaders, admission to graduate programs should be highly selective, a fourth distinctive feature. Fifth, graduate students should be challenged to consider, define, and discover significant gaps and needs in the field that can be addressed through better managed

programs, systematic evaluation and research, and leadership through policy making. Ultimately, graduate education should increase the capacity of graduate students to contribute to health, society, and the profession.

Graduate education is largely understood by the processes that students undergo from application to graduation. There are three basic components:

> Inputs such as the admissions process and the institutional resources available for preparing students, including faculty.
>
> Environments for preparation that include the experiences students have as part of their preparation, in and out of the classroom.
>
> Outputs of the educational process that typically include some form of summative evaluation through an examination or scholarly work and professional placement.

These core foundations factors of health education form the crucible for preparing health education leaders of tomorrow.

Assumptions, Values, and Beliefs

Underlying perspectives that guide the field have only been sparsely identified over the years (Nyswander, 1981; Oberteuffer, 1953) since health education began to emerge as a distinct field of study and profession. Unstated or implicit viewpoints need to be raised, examined, and considered in order to assess the direction and appropriateness of changes occurring in our field as society changes.

Certain assumptions underlie health education and influence professional preparation, particularly at the graduate level where leaders in the field emanate. Health education presumes that health status and longevity can be improved through purposive, planned,

and implemented interventions and presumes that the reverse is true: To not intervene into health concerns will adversely affect health status and limit life span. It is also assumed that the behavioral aspects of health can be separated from other facets for identification, analysis, and intervention. These presumptions includes a core cultural trait that problems can be actively identified and solved. The spread of health education programs from schools and public health agencies to voluntary health agencies, medical care organizations, and business and industry reflect this activist, interventionist orientation. In a similar vein, the discipline prizes individual self-determination and emphasizes individual determination of health status, almost to the exclusion of policy-making.

Health education, particularly at the graduate level, presumes that in depth preparation in higher education is necessary for successful practice. This point-of-view is supported by the extensive and intensive nature of graduate education, combining behavioral and natural sciences with approaches and methods to plan, implement and evaluate complex interventions, to conduct research and demonstration projects, and to administer programs. Included is the expectation that those with graduate degrees are prepared to assume positions of leadership in practice sites and professional organizations. Preparation also assumes that professional socialization into the underlying philosophy (point-of-view), purposes, history, and values of health education is necessary for graduates to effectively establish a career in health education, and to assume leadership roles.

Values and beliefs of health educators, reflecting underlying assumptions, are found in the literature of the field, and in interactions with health education practitioners. An excellent example is found in "Reflections: The Philosophies of Health Educators of the 1990s" (Eta Sigma Gamma, 1993). While it is not possible to identify all underlying values and beliefs, the following are representative of the profession.

As a group, health educators believe that their interventions reflect the value of health as a cornerstone of the quality of life.

Health educators also value their capacity to develop and implement programs for target audiences with whom they interact. Moreover they view the opportunities to work with program participants as rewarding experiences. Health educators believe that their programs empower individuals to take control of their health. Empowering others to be able to choose and act wisely for their own benefit is another fundamental value found in the profession.

Depending on preparation and experience, health educators sometimes diverge on the value of either the content or the processes used in their programs. For some, knowledge about issues, such as HIV/AIDS, is essential to the practice of health education (Jackson, 1990). For others, the process of planning, developing, and implementing programs is the essence of health education practice, particularly when target audiences are involved in all phases of the process.

These differences illustrate another important value found in health education, individual judgment and self-determination. This value extends to the profession, which may account for the numerous professional organizations to which health educators belong. It may also account for cycles where health educators, regardless of their disparate views, find common ground for advancing the field (Proceedings of the Workshop, 1978 &1981) and then drift toward more of a separatist frame of mind.

Scientific Foundations and Technologies

Throughout the development of professional preparation programs, the scientific basis for health education has been fundamental, deriving from the natural and behavioral sciences. In the information explosion as described by Toffler (1971), more is known about the contributing factors to health than ever before. The knowledge explosion has led to, and been extended by, communication networks and computers, creating demand for those with highly specialized knowledge and skills in particular areas.

Key to distinguish health education from other fields is the ability of health educators to use available technologies to influence health behavior. Much of the work of health educators is based on adaptations and applications of theories and models developed in psychology, sociology, education, economics, political science, and other fields, as well as those developed in the field; and development of biomedical sciences has helped define health education program content, strategies and desired outcomes. The use of diverse sources to form the knowledge base for health education also reflect the field's distinctive quality of integrating educational, health and biomedical knowledge and skills in programs, research, and policy development.

Because of developments in credentialing for health educators, emphasis has been placed on identifying essential competencies that health educators need to be able to perform, both intellectual and procedural. These competencies are the foundation for entry-level, or undergraduate degree, health educators. At the graduate level, there are no currently identified core competencies expected of masters and doctoral level preparation. Nevertheless, program faculty are in position to identify and develop these competencies from guidelines of professional organizations and accrediting guidelines from the Council on Education for Public Health, for example.

Health promotion programs have typically been based upon risk factor reduction. Through computer hardware and software technologies longitudinal epidemiological studies have been conducted which have led to the development of the concept and identities of risk factors for specific diseases and conditions. Many of these risk factors are behavioral in nature, such as diet, alcohol consumption, and exercise. While promising in attempting to explain the etiology of diseases and conditions, risk factors present some significant difficulties for health education programs that attempt to influence health status. Risk factors tend to be weak predictors of the occurrence of disease, their presence does not mean that disease will occur, nor does their absence mean that disease will not occur. In combination with risk factors, applied

theories and models represent the core technology of health education and are complemented by communication technologies and networks.

Communications networks include those that allow health educators to gather relevant information necessary for program planning. Available data bases and computerized analytical models enable health educators to rapidly respond to the need for developing health education programs that target specific groups with specific educational messages. These developments contrast with health educators valued practice of involving target audiences in problem identification and program planning and implementation.

Communications technologies have expanded the number of channels available to reach target audiences. Traditional one-on-one and group/class interactions remain as the centerpiece of program delivery, yet there is constant pressure for health educators to find more efficient and effective means of reaching audiences. Communications are further complicated by the increasing volume and diversity of health information within easy reach of the public. Emphasis on helping the public to evaluate health information, products, and services has been heightened by rapidly expanding communications.

For health education programs, the overwhelming amount of highly specialized knowledge of the facets of health and the skills necessary to effectively use such information continues to create a demand for health education professionals. It is difficult for those in need of professional services to recognize which service is required, or even that a need exists and that there are professionals who can address these needs. There are multiple and overlapping professions that offer competing services that appear to be equally capable of meeting specific needs. Professionals have increasingly relied upon marketing their services, within their own organizations and among targeted clientele. Initially this strategy helps to make connections between practitioners and potential clientele and has been extended to help maintain, if not expand, their scope of practice. As a result, concepts and strategies of social marketing

have become part of the knowledge and skill base of health education specialists.

Collaboration

With the rapid expansion of specialized health-related professions in response to the information and technology explosion, the need for health educators to collaborate with other professionals has never been greater. Much of the focus of professionalism has been on the independent, self-directing, self-regulating occupation: Medicine. Few occupational groups enjoy this level of autonomy. Even medicine no longer fits this ideal in that physicians must rely on other specialties in and out of their own discipline to meet the challenges of their profession. What has emerged in recent years is the concept of interdependence. Whereas health educators focus on individual behavior change, their programs often require many different kinds of expertise to be effective. It is also recognized that organizational changes are needed to make health education programs work as well as behavior change. Such change affects not only the intended educational audiences, it also touches those who participate in such programs. In many instances, health educators find themselves to be in small or singular numbers in a practice setting, demanding that they work with colleagues from other disciplines as part of their daily work.

The challenge to health educators goes beyond the recognition of the need for collaboration to the capacity to identify and work with those who are needed to make health education programs work. Professional preparation experiences should provide some opportunity for collaboration in and out of the classroom. Often, because many graduate students already have degrees or preparation in other disciplines, graduate students are able to learn from each other's backgrounds. This is not necessarily a deliberate feature of graduate preparation, although thoughtful consideration of how graduate admissions are conducted ought to be given attention.

Ironically, most health-related professions and health education graduate professional preparation programs function in isolation in colleges and universities. A brief review of the Eta Sigma Gamma or Association for the Advancement of Health Education directories of undergraduate and graduate programs underscores this situation. Professional preparation programs are found in many different organizational units in colleges and universities. Some programs are part of departments with other professional preparation programs. The variety of organizational arrangements for health education in colleges and universities may not afford opportunities for graduate students to be able to work with those in other professional fields, with the possible exception of the internship experience.

Typically, those with graduate degrees are considered for supervisory and administrative positions within an organization. Effective health education programs require coordination of scarce resources, often outside the purview of the health education program. In these lateral relationships, abilities to discover mutual goals and objectives with other professionals and to collaborate with them are essential to successful programs.

Leadership

Leadership skills are among the most distinguishing features of graduate preparation in health education. Courses in leadership are rarely found in professional preparation programs, aside from a single course in administration and/or supervision. Accordingly, careful admissions processes that help to assess leadership potential of applicants are essential to recruiting and preparing future leaders.

Without much specific preparation, the socialization process of graduate students into the field must give them expectations that they will assume responsible positions and will participate in helping to advance the profession. Student internship experiences, class projects, student organizations, participation in faculty research and evaluation projects, and participation in local, state, or

national health education organizations assist in the socialization process.

Contrary to popular myth, leaders are made, not born. Leaders are created through a social learning process that is significantly influenced by purposive involvement in situations requiring initiative, collaboration, imagination, and analytical and communication skills. Repeated, graded experiences in leadership provided by mentors in leadership experiences help prepare new leaders. These experiences should begin during professional preparation and continue through internship and placement after graduation. Expectations must be established by faculty that students participate in one or more activities to assist the development of the field. Similarly, those whose focus is on scholarly research activities need to be nurtured by involvement in the preparation and submission of grants and in the conduct of faculty research. Class experiences in research methods can assist in this process as well.

Among the qualities of leadership essential to graduate students is the ability to advocate for health education. This may occur within the health educator's employing organization in order to preserve or extend the health education unit within the organization. It may be viewed as an educational process for those who have decision-making authority about the health education program and its resources but lack an understanding of the field and its contributions to the organization. Other forms of advocacy involve working in communities to help shape or change public policies toward a more health-enhancing social environment. Often these changes will facilitate the continuation of health education programs as well as movement toward making the social environment consistent with health education messages. Many times this form of advocacy will require health educators to collaborate with others in the community and their sponsoring organizations to be effective.

Graduate Professional Preparation

Graduate programs represent a significant investment by all

parties involved in higher education, students, faculty, and college or university. The character of graduate education is formed by the mission, goals, and objectives of the sponsoring institution, the profession in question, the surrounding community, alumni, program faculty, and students. Carefully crafted, graduate education is a distinctive experience whose purpose is to shape the career of the graduate student as they progress through the program, graduate, and assume a position within the profession. It is characteristic of these programs that students become colleagues of their faculty often during the education process and after graduation. As some graduate students move on to doctoral programs, they may well become faculty colleagues with their former professors. The collegial and intensive nature of graduate education helps to perpetuate professions, even though fields, like health education, may rapidly evolve after graduation.

Graduate programs are distinctive because they typically involve a small number of highly selected students who work intensely with program faculty in a supportive, yet demanding, environment. As such, the process of selecting graduate students is a crucial step in developing tomorrow's leaders. Consideration of the applicant's prior education (major and grade point average), relevant experience, expressed interest and intent for graduate education, standardized test scores, and letters of recommendation are all used as admissions criteria. Some or all may be used, but, in any event, admission decisions need to be weighed on a balance of factors.

One point of contention for graduate admissions is the presumption that the applicant has an undergraduate degree in health education, on the one hand, or that an applicant may come from another discipline and still be eligible for admission, on the other. Many health education graduate programs are built on one supposition or the other. That is, preparation may be concentrated in intensive, but limited, number of credits involving an internship or a scholarly work, or both. Other programs have more extensive preparation with more credits with the presumption that the program's curriculum will prepare a health educator regardless of

the student's prior educational background. There are no easy answers to this dichotomy. In fact, many programs maneuver around this issue by requiring those without a health education background to take pre-requisite courses as a condition for admission to the graduate program.

Once admitted, students need to be socialized deeply and pervasively into health education, its concepts, values and beliefs, ideals, issues, history, intellectual foundations, professional organizations, and its contributions to society. This represents both a broad perspective of health education but very narrow focus. Experiences need to allow graduate students to make connections between health education and their communities and society, including issues surrounding rapid changes in our social environment and the social and health issues that arise from such change.

Graduate programs need to be differentiated from undergraduate programs through development of basic tenets of an evolving profession, such as the degree to which the field is autonomous and is governed by ethical principles. The capacity to tackle complex social issues and tease out the behavioral aspects among them that affect health needs to be developed. This will assist graduates to be able to advocate for the field and be able to carefully identify which needs and interests should be addressed. By creating an agenda for action, graduates will assert their leadership within their organizations. Furthermore, graduates need to have the research and evaluation skills necessary for investigation of the relative merits of health education interventions, and for systematically assessing the need for health education programs from community and scientific data sources.

Graduate level health education specialists also need to be prepared to identify and evaluate the gaps and needs in the discipline. While there has been a great deal of progress in health education research and evaluation studies, in the creation of program planning models, and in behavioral science theories and models, much remains to be done (Clark &McLeroy, 1995). Students should be encouraged, if not required, to pursue investigations of these areas of need through theses and dissertations, as

well as through working with faculty on their scholarly activities. The considerable achievements reflected in health education investigations and program evaluation have given health education credibility in educational and public health arenas.

Lastly, graduate health education students need to be oriented toward asserting leadership in the profession and in practice settings. Fundamentally, leadership requires the ability to communicate effectively at all levels within an organization. Because they are often the only ones in their organizations, health educators need to be prepared to make independent judgments and know when it is appropriate to act on these judgments. The wisdom to know when its appropriate to consult and collaborate with others also needs to be inculcated.

Conclusion

Graduate education in health education has grown and evolved rapidly in the past several years. The scientific base and technologies available to health educators have grown substantially and are more broadly available than ever before. Professional organizations are thriving. Health education has had more influence at local, state and national policy-making in the last several years than in the past. On the other hand, some preparation programs have dissipated and have not had the capacity to meet the needs of graduate students and disappeared. For others, their capacity and commitment to educating graduate students has grown.

While there is some basic agreement in the field about core preparation, the context and substance of graduate preparation has not had much attention for many years. Yet, graduate programs have produced and continue to produce leaders in the field. Momentum for health education programs has never been higher. To sustain and broaden the advances health education has enjoyed for the past several decades, commitment by the profession must be made to attend to and nurture graduate professional preparation.

References

Clark, N.M. (1994). Health educators and the future: Lead, follow, or get out of the way. *Health Education, 25*(3), 136-141.

Clark, N.M.; McLeroy, K.L. (1995). Creating capacity through health education: What we know and what we don't. *Health Education Quarterly, 22*(3), 273-289.

Creswell, W.H. (1981). Professional preparation: An historical perspective. *National Conference for Institution Preparing Health Educators*. Washington, DC: DHHS Publication No. 81-50171.

Guinta, M.A.; Allegrante, J.P. (1992). The president's committee on health education: A 20-year retrospective on its politics and policy impact. *American Journal of Public Health, 82*(7), 1033-1041.

Jackson, M.L. (1990). Contentions for the future of health education: Beliefs of potential professional health education leaders. *Health Education, 21*(3), 6-9.

Johns, E.B. (1977). *Graduate health education: Past, present, and future*. Atlanta, GA: Eta Sigma Gamma Annual Meeting.

Nyswander, D.B. (1980). Public health education: Sources, growth and operational philosophy. *International Quarterly of Community Health Education, 1*(1), 5-18.

Oberteuffer, D.K. (1953). Philosophy and principles of the school health program. *Journal of School Health, 23*(4), 103-109.

Reflections: The philosophies of health educators of the 1990's (1993). *Eta Sigma Gamma Monograph Series, 11*(2),

Proceedings of the Workshop on Commonalities and Differences (1978). *Preparation and Practice of community, Patient, and School Health Educators*. Washington, DC: DHEWPublication No. (HRA) 78-71.

Shirreffs, J.H. (1980). Health education: An emerging profession. *Health Education, 11*(1), 7-10.

Toffler, A. (1971). *Future Shock.* New York: Bantam Books.

CHAPTER 2

EVOLVING GRADUATE PROGRAMS IN HEALTH EDUCATION

William H. Creswell, Jr., Ed.D.
Ann E. Nolte, Ph.D.

Graduate programs in health education have existed in the United States since 1921 when Clair Turner, D.Sc., developed a program of graduate training in health education at Harvard-Massachusetts Institute of Technology. Many forces and factors have influenced the growth of programs in these 74 years, resulting in the current 137 graduate programs. This evolution of programs has involved changes in higher education, changes in public health, the defining of health education as a profession through accreditation and credentialing, and the development of graduate programs in health education.

Changes in Higher Education

Donald Kennedy (1995), president emeritus of Stanford University, indicates that changes in higher education are beginning to occur. The focus during the past century has been on research and academic freedom. Now the public is becoming concerned with the quality of education provided. Current trends in higher education, such as adopting corporate characteristics of marketing, productivity enhancement, and Total Quality Management have created problems, because these often do not fit into the university setting.

Another development is the assertion of more control over the research and work of the faculty. Focusing on professional responsibility and ethics is becoming more significant as faculty

members become more aware of their roles as mentors. Mentoring is not a responsibility left to the distinguished faculty but is becoming recognized as a characteristic of all faculty. Teaching skills are receiving attention in departments other than those within colleges and schools of education. Kennedy (1995) states that "even more importantly, peer review of teaching will become just as much a custom as peer review of research" (p.15).

These changes occurring in higher education will affect the preparation in health education, primarily because it is integrally linked with the belief of facilitating the whole person.

Changes in Public Health

A series of national conferences and forums have been held to help redefine the role of public health. The change in the focus of medical care will mean that in the future public health will give less emphasis to providing direct health services and will concentrate on population-based services for the entire community. This new emphasis for public health will require new partnerships to provide information derived from community health needs and health services to the community (Baker, et al., 1994).

In such a community-based health approach, the health educator must play a key role in informing and interpreting the public health program. This role will include efforts to mobilize community partnerships involving and empowering people to solve community problems. Further, this effort will involve the public school system and other non-health agencies of government, including churches and social service organizations, as well as institutions of higher education. The health educator, using educational and communication skills, can make an important contribution to development of coalitions essential to building healthy communities.

Professional Preparation in Health Education

The professional preparation for health education, especially at the advanced graduate level, entails a fully-functioning partnership between the professional fields of public health and education. The outcomes of such a joint enterprise provide a professional preparation program that includes competencies in public health, the behavioral sciences, and education.

Understanding the context and the orientation of the two fields is important to the study of health education. Fineberg, et al. (1994), writing for the Annual Review of Public Health, have identified the following areas as fundamental to preparation in public health: the measurement and analytic sciences of epidemiology and biostatistics, the history and philosophy of public health including social policy, and the management and organization of public health. The foundational fields for education include the following: history and philosophy of education; social and behavioral sciences of anthropology, sociology, and psychology; learning theory and methodologies of behavioral change; curriculum development; instructional methods; and evaluation.

Health Education Research

Major strides in the growth and quality of health education research have occurred over the past two decades. No less than six national journals are devoted exclusively to publication of scholarly papers in the field of health education. Paralleling these developments is a growing national recognition of the importance of human behavior in the prevention of disease, and in the maintenance as well as in the promotion of individual and societal well-being. Both government and professional health organizations have enacted public policy which recognizes the importance of health education.

In a recent national conference, the term health education research "was used to encompass the study of health-related social and behavioral interventions" (The Society of Public Health Edu-

cation, May, 1995. p. 270). Through the joint sponsorship of the Society of Public Health Education and the offices of the National Centers for Disease Control and Prevention, a national forum was held to make recommendations for research needs, the related interventions, and the health education outcomes. This conference resulted in a landmark publication which has brought together a series of background papers around five research-related topics:

1. Theories and principles underlying interventions in health education.
2. The settings for conducting health education research.
3. Strategies for health education research.
4. Evaluation designs and methods.
5. The needs of special populations.

Scholars in the field of health education will find this document a benchmark reference on the status of health education research together with suggested topics and study questions. Each of the five background papers has a comprehensive reference list of the relevant research. (Society of Public Health Education, May, 1995).

Credentialing

Credentialing is a process which has become a hallmark among the health professions. It represents either licensing or certification of individuals who are working directly with clients. The profession of health education initiated efforts to establish credentialing in 1978. Since that time, procedures have been established which provide for the certification of individuals who complete a professional program of study in the field of health education at the bachelor's degree level or above and who pass the certification examination. Cleary (1995) states that "...credentialing is not the total answer to every profession's problems, but it can improve the quality of professional preparation and of professional practice."

Accreditation

Accreditation in the United States is a system of voluntary non-governmental evaluation. However, accreditation is used as a standard in many formal actions. For example, the decision to award federally funded program grants, scholarships, and traineeships to colleges and universities offering graduate education in public health including health education is determined by the accreditation status of the proposed recipient.

Type of Accreditation

The United States recognizes several types or levels of accreditation. First are the national and regional accrediting bodies, whose focus is the total institution. They assess the entire institution rather than a particular program and determine the validity and integrity of the institution as a whole. Periodic revisits are conducted to reaffirm the accredited status. These regional Associations of Colleges and Schools include Middle States, New England, North Central, Northwest, Southern and Western. Second are the specialized accreditation groups whoare concerned with evaluating a specific field, such as law, medicine, or education. Finally, there is the umbrella organization that serves as an accrediting agency for all other accrediting bodies.

As stated in the *1993-1994 Accredited Institutions of Postsecondary Education* (Wade, 1993-94, p. 668), "In America, accreditation at the postsecondary level performs a number of important functions, including the encouragement of efforts toward maximum educational effectiveness." The system of accreditation promotes regional and national approaches to the determination of educational quality.

Each of the national accrediting organizations in fields such as law, medicine, education, or public health has its own unique definition and criteria for accreditation and operating procedures. The purpose of these accrediting activities is to provide quality

assurance concerning the educational preparation of the students for a specific professional field of service.

Accreditation Issues

Important as accreditation is, it is not without its critics. From its inception, the driving force behind accreditation has been the need to establish standards and to assure the quality of programs. Koerner (1994) contends that the regional accrediting groups have become unresponsive to demands for reform in higher education. Another long-standing criticism is their lack of agreement on a common set of standards to evaluate institutions of higher education. On the other hand, the regional bodies argue that because of regional differences, their criteria and standards must differ.

Increased pressure on accrediting agencies has resulted from new legislation relating to the 1992 Reauthorization of the Higher Education Act. This Act led to an increased number of requirements that accrediting agencies must meet in order to assure that the accredited institutions are fully qualified and eligible for recognition by the Department of Education. This set of requirements becomes an all-important consideration if colleges and universities are to qualify for federal funds.

The Department of Education has moved ahead with its own plans and has appointed a panel to review accrediting agencies. "Many colleges have feared that the panel would use the Department's regulations to micro-manage the accrediting groups" (Ornstein, C., July 6, 1994, p. A36). As a consequence, the whole accrediting process is coming under critical reexamination. The American Council of Education, the regional accrediting bodies, and leaders of American higher education have met to deliberate on the development of a new national structure that may more effectively serve the need for accreditation.

Accreditation for Health Education

In the field of health education, members of the profession became concerned about accreditation for institutions preparing community health educators. Their concerns were two-fold: (a) the need to gain recognition of their programs in order to be eligible for federal funds, and (b) the need to assist their students in job placement. During the period of 1945 to 1973, the official accrediting body for community and public health professions was the American Public Health Association (APHA). In the early development of public health, professional preparation was, to a large extent, confined to schools of public health. As a consequence, the accrediting by APHA was limited to schools of public health (Council on Education for Public Health [CEPH]). This meant that those institutions outside of the schools of public health which were offering graduate professional preparation in community health education had no means of becoming accredited.

After presenting their case to the Council on Postsecondary Accreditation (COPA), the umbrella organization, it was determined that a new agency with a broader responsibility for accrediting graduate preparation in public health and its related discipline of health education should be formed. This led to the creation of an independent body, CEPH , which has served as the recognized accrediting agency for the profession since 1974.

According to Patricia Evans (1995), Executive Director for the Council on Education for Public Health, institutions presently holding CEPH accreditation include the following: the 27 schools of public health, 15 institutions with preventive medicine/community health accreditation, and 10 institutions with community health education accreditation. The latter groups represent institutions other than the schools of public health.

*Surveys of Graduate Programs in Health Education**

As shown in Table 1, the 1995 edition of the Association for the Advancement of Health Education (AAHE) "Directory of

Institutions Offering Undergraduate and Graduate Degree Programs in Health Education" indicates 137 graduate programs in 43 states. The initial survey was conducted in 1976, and numbered 111 programs in 35 states. The greatest number of programs was reported in 1984, with 150 programs in 40 states. Apparently six states, Alaska, Delaware, Nevada, North Dakota, South Dakota, and Vermont did not have graduate programs at that time. Four states failed to return the survey forms.

---

* Data for this section are from the surveys conducted by the Association for the Advancement of Health Education during the years 1976, 1978, 1980, 1982, 1984, 1986, 1989, 1991, and 1995. They represent data from the surveys that were returned. (See references AAHE 1976 - 1995 for listing of these directories.)

Table 1

Number of Graduate Programs in Health Education and Number of States with Programs, 1976-1995

	1976	1978	1980	1982	1984	1986	1989	1991	1995
Programs	111	126	138	148	150	149	147	133	137
States	35	37	39	40	40	43	41	41	43

Changes in the number of programs may be due in part to the reporting procedure. The surveys are distributed nationally to every college and university. The health education personnel complete the survey forms and return them to the Association. Telephone follow-ups are made but there are nonrespondents. Also, it is known that from 1990 to 1995 some graduate programs have been phased out due to financial constraints or consolidation of programs.

Regional Distribution

Table 2 shows the distribution of graduate programs nationally was analyzed by assigning the states into the districts used by the American Alliance for Health, Physical Education, Recreation, and Dance for their organizational purposes.

Table 2

Regional Distribution of Graduate Programs in Health Education, 1976-1995

	1976	1978	1980	1982	1984	1986	1989	1991	1995
Eastern (11 states & DC)	29	32	33	33	36	36	36	27	29
Southern (13 states)	33	42	46	52	52	53	51	49	48
Midwest (6 states)	18	22	23	25	27	25	21	23	21
Central (9 states)	8	8	12	14	13	10	12	14	13
Northwest (5 states)	6	6	8	8	7	9	11	6	8
Southwest (6 states)	17	16	16	16	15	16	16	14	18
Total	111	126	138	148	150	149	147	133	137

The greatest number of graduate programs is in the Southern Region (13 states). This has been consistent since 1976. The least number of graduate programs is in the Northwest Region (5 states) and this, also, has been consistent since 1976. The Central Region represents nine states; however, it has fewer graduate programs than the Midwest Region, representing only six states. This also has been consistent since 1976 (Association for the Advancement of Health Education [AAHE], 1976).

The regional distribution points out several concerns for the profession. First, is there access to graduate studies for entry-level professionals working in states with few or no programs? Second, is there leadership and the support needed for health education within those states with few or no programs? Third, is continuing education available for the certification of health education specialists in those states with few or no programs? Although these concerns can be resolved without having access to graduate programs, it is a problem identified by this regional distribution as shown in Table 3.

Table 3

Number of Doctoral Degrees Awarded in Health Education by Geographic Region for the Years 1992-1994*

Regions	1992	1993	1994	Totals
Central (9 states)	8	7	2	17
Eastern (11 states)	15	25	34	74
Midwest (6 states)	17	17	8	42
Northwest (5 states)	1	1	1	3
Southern (13 states)	26	32	27	85
Southwest (6 states)	3	3	4	10
Totals	70	85	76	231

*Source: University Microfilm, Inc. Company. 1995. [doctoral dissertations]

Degree Titles

The *1989 Directory of Institutions* (AAHE, 1989) was the first edition to request that titles of graduate degrees be listed, e.g.,

M.S., Ph.D. Titles were also included in subsequent editions. There are 35 different degree titles offered in the graduate programs in the United States. The majority of titles are Health Education, followed by Community Health and Health Science. Table 4 shows the remaining 33 range from variations of the above to unique and quite distinct titles.

Table 4

Titles of Degrees in Graduate Programs, 1989-1995

Administrative Support of Health Education	Health Promotion and Disease Prevention
Behavioral Science and Health Education	Health Promotion and Wellness Mgmt.
Community and Family Health	Health Promotion Education
Community Health	Health Science
Corporate Health	Health Science Education
Health Administration	Health Services Administration
Health Administration and Planning	Health Studies/Safety
Health and Human Performance	Industrial Health Education
Health and Safety Education	International Community Health Education
Health Behavior	Philosophy in Health Education
Health Care Administration	Public Health
Health Education	Public Health Education
Health Education and Health Care Admin.	Public Health Promotion and Education
Health Education for Health Care Practitioners	School Health
Health Education/Health Behavior	Wellness Programs
Health Education/Health Promotion	Worksite Health

The variety of titles may well represent some of the problems the profession is having in establishing itself and achieving recognition by other professions and the public at large. It might also represent a potential problem of credibility within academic institutions where programs are being questioned due to financial constraints. If programs are to be accredited and professionals certified, then this inconsistency in titles of degrees is a potential problem.

While there has been an increase in the number of institutions accredited for health education since the mid-1970s, relatively few of the institutions listed in the 1995 Association for

Advancement of Health Education Directory (AAHE) hold CEPH accreditation. Some of the findings from this review are highlighted as follows:

Masters Degree

- One hundred thirty-six (136) institutions offer the master's degree in health education. Twenty (20) of these master's degree programs are offered by schools of public health, while 116 programs are offered by other colleges and universities.

- According to the AAHE (1995) Directory, 19 institutions (13.9%) offering the master's degree in health education have CEPH graduate program accreditation status. Of the 116 institutions other than the schools of public health offering the master's degree program in health education, only 10 (8.6 %) hold CEPH accredited status.

Doctoral Degree

- Table 5A lists forty-one (41) institutions which offer the doctoral degree in health education.

- All 11 schools of public health that offer the doctoral degree in health education have CEPH accreditation status (100%). Of the 30 institutions without schools of public health offering the doctoral degree, only 4 (13.3%) hold CEPH graduate program accreditation.

- According to the University Microfilm Incorporated Company abstract service, 7 of the 11 graduate schools of public health awarded no doctoral

degrees in health education during the three year period of 1992 to 1994.*

* According to MCI reports only four schools of public health awarded doctorates in health education (1992-1994): Loma Linda University, University of South Florida, University of North Carolina, and the University of South Carolina.

Table 5A

Number of Institutions Offering the Doctoral Degree in Health Education by Type of Institution and by CEPH Accredited Status (1992-1994)

Type of School	CEPH Accredited	Non-Accredited	Row Totals
School of Public Health	11	0	11
	(26.8%)	(0%)	(26.8%)
Other Institutions	4	26	30
	(9.7%)	(63.3%)	(73.2%)
Column Totals	15	26	41
	(36.5%)	(63.3%)	(100%)

Source: Directory of Institutions Offering Undergraduate and Graduate Degree Programs in Health Education, *Journal of Health Education, 26*(2), 107-118.

Conclusions and Implications

What conclusions or implications can be drawn from this review of graduate program activity and accreditation? With such

a low number of the non-schools of public health holding accredited status, and only four schools of public health awarding doctorates in health education during this period of time, a question might well be raised about the role and importance of accreditation to the field of health education.

As stated in the *Directory of Accredited Institutions of Postsecondary Education*, the purpose of accreditation is "...to foster excellence through the development of uniform, national criteria and guidelines for assessing educational effectiveness" (Wade, 1993-94, p. 669) and to assure the educational community as well as the public at large that the profession of health education has clearly defined purposes and objectives that are appropriate to serving the public's health and educational needs.

Because of the relatively low rate of participation in the accreditation process among the institutions without schools of public health, Bensley (1990) has spoken forcefully to this issue. "At the present time, there is no assurance that graduate programs in health education have the quality and integrity to produce competent individuals." (Bensley, 1990, p. 59).

Moreover, in today's environment as well as in the future, there is increasing demand for accountability. Strong public pressure for consumer protection means that there must be public assurance that our graduates possess the qualities to serve society and which will, in turn, command the respect of the profession (Ewell, 1994).

With regard to the leadership in health education, have the schools of public health made a conscious decision to de-emphasize professional preparation in health education at the doctorate level? Table 5B shows only four (4) of the 27 schools awarded 18 doctoral degrees in health education during the three year period of 1992-1994. Is the mantle of leadership being passed to institutions other than schools of public health?

Strong and effective accreditation has made an important contribution to the quality and integrity of higher education in America. This has been accomplished by helping institutions as well as the professions to develop criteria and guidelines for

assessing educational effectiveness. Accreditation is an on-going and evolving process whose purpose is program integrity while protecting the public's interest in program quality.

Table 5B

Number of Doctoral Degrees in Health Education[1] Awarded by Type of Institution and by CEPH Accredited Status (1992-1994)[2]

	Number of Degrees Awarded		
CEPH Accredited Status	Doctorates Awarded by Schools of Public Health	Doctorates Awarded by Institutions without Schools of Public Health	Row Totals
Accredited	18 (7.8%)	25 (10.8%)	43 (18.6%)
Non-Accredited	0 (0%)	188 (81.4%)	188 (81.4%)
Column Totals	18 (7.8%)	213 (92.2%)	231 (100%)

[1]Source: University Microfilm, Inc. Company. 1995. [dissertation abstract service].
[2]Source: Association for the Advancement of Health Education (March-April 1995) Directory of Institutions Offering Undergraduate and Graduate Degree Programs in Health Education. *Journal of Health Education, 26*(2), 107-118.

Prospects For the Future

Despite apparent problems, the future of graduate programs in health education appears bright. The changes in public health,

higher education, credentialing, and accreditation provide a framework for developing long term goals and a productive future for the health education profession. Graduate programs and research will provide strength of leadership and direction. To assure continued progress in the development of graduate programs for health education, the following recommendations are offered:

- A national data bank should be established and maintained on a continuing basis relating to the need for health educators at the bachelors, masters and doctoral levels of preparation. This data base should also include the number of professionals in practice by location, type of institution, and certification status.

- A national conference on health education should be called by the relevant professional organizations for the purpose of developing policies relating to the issues of certification and accreditation. Special attention should be given to the accreditation of doctoral programs.

- A national conference on graduate preparation for health education should be sponsored by the national health education organizations for the purpose of conducting a critical review and evaluation of programs in light of contemporary developments in higher education and public health.

- A series of forums on health education research should be conducted as a followup to the September, 1994 research conference held in Atlanta, Georgia.

- Partnerships between the fields of education and public health should be developed at the local, state, and national levels to give renewed emphasis to disease prevention and to health promotion programs.

- A close working relationship should be established between the faculties of the schools of public health and the health education faculties from the institutions without schools of public health for the purpose of facilitating communication and coordination in resolving issues of importance to the profession.

References

Afifi, A. A. & Breslow, L. (1994). The Maturing Paradigm of Public Health. In *Annual Review of Public Health, 15*, 223-234.

Association for the Advancement of Health Education. (1976). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparations in health education. Health Education, *7*(6), 27-33.

Association for the Advancement of Health Education. (1978). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Health Education, 9*(6), 35-43. This directory indicates that it is the 1979 edition, but it was published in 1978.

Association for the Advancement of Health Education. (1980). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Health Education, 11*(5), 29-38. This directory indicates that it is the 1981 edition, but it was published in 1980.

Association for the Advancement of Health Education. (1982). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Health Education, 13*(5), 31-39. This directory indicates that it is the 1983 edition, but it was published in 1982.

Association for the Advancement of Health Education. (1984). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Health Education, 15*(4), 80-88. This directory indicates that it is the1985 edition, but it was published in 1984.

Association for the Advancement of Health Education. (1986). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Health Education, 17*(4), 39-48. This directory indicates that it is the 1987 edition, but it was published in 1986.

Association for the Advancement of Health Education. (1989). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Health Education, 20*(4), 42-54.

Association for the Advancement of Health Education. (1991). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Journal of Health Education, 22*(6), 365-382.

Association for the Advancement of Health Education. (1995). AAHE directory of institutions offering specialization in undergraduate and graduate professional preparation programs in health education. *Journal of Health Education, 26*(2), 107-118.

Baker E. L., Melton, R. J., Stange, P. V., Fields, M.L., Koplan, J. P., Guerra, F. A. & Satcher, D. (1994). Health reform and the health of the public: Forging community health partnerships. *Journal of American Medical Association, 272*(16), 1276-1282.

Bensley, L. B. (1990). A perspective on lack of continuity and standards of master's degree programs in health education and health promotion. *Health Education, 21*(2), 59-60.

Clark, N. M. & McLeroy, K. R. (1995). Creating capacity through health education: What we know and what we don't know. *Health Education Quarterly, 22*(3), 270-289.

Cleary, H. P. (1995). *The credentialing of health educators: An historical account 1976-1990.* New York: The National Commission for Health Education Credentialing, Inc., p. vii.

Council on Education for Public Health the Accrediting Agency for Graduate Education in Public Health. Washington, D.C. 1015 Fifteenth St. N.W. Suite 403.

Evans, Patricia, Executive Director, Council for Education of Public Health, (telephone conversation) July 27, 1995.

Ewell, Peter T. (November/December 1994) Accountability and the Future Self-Regulation. *Change, 26*(6), 25-29.

Fineberg, H. B., Green, G. M., Ware, J. H. & Anderson, B. L., (1994) Changing public health training needs: professional education and the paradigm of public health. In *Annual Review of Public Health, 15*, 237-257.

Institute of Medicine (U.S.) 1988 Committee for the Study of the Future of Public Health. *The Future of Public Health.* Washington, D. C.: National Academy of Medicine.

Johnson, L. E. (1994). An analysis of health education professional preparation programs and faculty. Unpublished thesis master's of public health degree, School of Public Health, Emory University, Atlanta, Georgia.

Kennedy, D. (1995). Another century's end, another revolution for higher education. *Change, 27*(3), 8-15.

Koerner, J. D. (1971, 1994). Academia's hidden cartel: Preserving the status quo. *Change, 26*(3), 65-68.

Ornstein, C. (1994, July 6) U.S. review panel on accrediting appears divided. *The Chronicle of Higher Education.* A36.

The Society of Public Health Education, (1995). Theme issue: Creating capacity: A research agenda for public health education. *Health Education Quarterly, 22*(3).

University Microfilm, Inc. Company. 1995. [dissertation abstract service].

Wade, W. A. (Ed.) (1993-94). *Accredited Institutions of Postsecondary Education Programs Candidates*. Washington, D. C.: American Council on Education. p. 668-669.

CHAPTER 3

OVERVIEW OF THE DEVELOPMENT OF GRADUATE HEALTH EDUCATION STANDARDS

Joint Committee for the Development of
Graduate Level Preparation Standards*

The profession of health education has undergone tremendous growth and evolution over the past few decades. Building on the foundations of thoughtful introspection and vision in the late 1950s and early 1960s, concerned professionals delineated and validated the roles and responsibilities of entry level health educators. This came about during a time when the public health leadership in the nation was working to establish a set of national health objectives. After defining the roles and responsibilities, attention turned to providing guidelines for the entry-level training programs to help them review and evaluate their curricula to see if the professional preparation programs were providing competency-based training for their health educators. Following two national consensus conferences (Bethesda, 1978; Birmingham, 1981), these guidelines for professional preparation program planning and evaluation were adopted.

Thus, there is in place a set of guidelines to help university programs prepare their health educators for professional roles. But guidance for entry-level professional preparation is not sufficient. The profession still lacks specific curricular requirements to guide graduate health education training. This has been the subject of discussions in the professional literature (Bensley & Pope, 1992). In this paper, we will discuss the history of professional roles and responsibilities, the need for and the value of a common framework for health education at the graduate level, and propose new areas of

responsibilities and competencies appropriate at the graduate level.

Chronology of the Graduate Standards Process

The Joint Committee for Graduate Standards was established by the Association for Advancement of Health Education (AAHE) Board of Directors in June 1992. The committee membership was comprised of members of the Society for Public Health Education and Association for the Health Education Baccalaureate Program Approval Committee (SABPAC) and the AAHE/National Council for Accreditation of Teacher Education (NCATE) Review Committee. All committee members have remained on the Joint Committee even if their tenure on the respective association committee expired. Letters were sent to the various health education professional organizations soliciting their active participation in the process. At that time, only the two founding organizations were actively involved in the process: AAHE and the Society of Public Health Education (SOPHE). Funding for the project was shared by AAHE and SOPHE. To obtain a broader perspective during this process, committee membership was expanded to include members from the Council on Education for Public Health (CEPH) and the National Commission for Health Education Credentialing, Inc. (NCHEC).

In October 1992, the Committee met in a two day retreat to determine how best to proceed. A budget was established and a long-term plan was drafted. The committee decided to use the "Framework's" list of responsibilities and competencies for entry-level health educators as a starting point from which to identify the competencies the committee members felt were germane to graduate-level preparation. It became apparent during the committee's discussions that three areas needed to be addressed:

1. To designate those competencies and subcompetencies that were exclusively pertinent to undergraduate preparation. The committee reasoned that all students entering graduate programs

will already possess these competencies, or the program will require students to gain those competencies before or during their graduate programs.

2. To add additional areas of responsibilities and competencies which were needed to ensure preparation for knowledge and skills required of health educators with advanced preparation.

3. To create new subcompetencies to enhance the existing areas of responsibilities and to support the newly created areas of responsibilities. The creation of these new areas was related to the expectations of graduate level students as they enter the job market.

The Committee's plan was to brainstorm, discuss, and refine these changes to the roles and responsibilities and develop a survey instrument that would be used to generate feedback and validation from health education practitioners. During the remainder of 1992 and the beginning of 1993 such an instrument was constructed to assess the value and relevance of the current roles, responsibilities, and competencies to graduate education. The instrument was reviewed and revised by the entire committee in April, 1993. The Committee then solicited universities to provide a list of professionals and practitioners from a variety of work settings (e.g., higher education, health departments) to respond to the instrument.

By October 1993, using the lists of names provided by the universities, the instrument was sent to 418 practitioners in the field. These surveys were returned during the winter of 1993-94. Comments from the first survey were used to modify the instrument for the second round of review from the field. A second draft was prepared, mailed to universities for input, and presented to interested parties during a session at the annual AAHE convention in March 1995.

The Committee met in July of 1995 to finalize the draft copy of the Graduate Level Competencies. At this same meeting, with

approval from the two founding associations, a national meeting was planned for February 8 - 10, 1996, in Dallas Texas. Invitees from all institutions preparing graduate level health educators will be invited in order to obtain direct input to further validate the competencies. Following the modifications arising from input at this meeting, the Joint Committee intends to provide the completed document to the profession through all appropriate means.

Rationale for New Areas of Responsibilities

The advanced nature of graduate study in health education implies that additional areas of responsibility are needed to ensure that graduates of advanced programs possess skills beyond those of entry-level practitioners. Discussions among the committee members and input from the field concluded with the development of three additional areas of responsibility which add on to the seven areas of responsibility which already exist in the Framework.

Area VIII: Applying Research Principles and Techniques to Health Education

Because students at the graduate level generally develop skills in data collection and analysis, and use the findings from research studies to develop and revise programs, this area was developed with specific competencies and subcompetencies to assure that graduate level curricula will include the application of qualitative and quantitative data.

Area IX: Managing/Supervising Health Education Programs in a Variety of Settings

In many practice settings, graduate level health educators are asked to assume significant management responsibilities. In some settings, supervision is a significant concern. For this reason, those involved in this role delineation felt that graduate programs need to include curriculum to assure quality management/supervision skills among their graduates.

Area X: Advancing the Profession of Health Education

A major responsibility of health education professionals with advanced skills and knowledge is to provide leadership services to individuals and organizations. It is expected that these services are planned and delivered in an ethical manner. This tenth area of responsibility was created to ensure quality leadership with an understanding of ethical principles.

The competencies which are being recommended for graduate level preparation reflect the premise that individuals entering these programs will already have been trained at the undergraduate level in the core competencies to practice health education, or that, by the time they complete their graduate education, they will have had an opportunity to receive training in the core, as well as the advanced Responsibilities & Competencies.

It is with this premise in mind that the committee highly recommends that students who have been accepted for graduate work in health education, but who lack specific discipline undergraduate training, be afforded every opportunity to receive training in the entry-level health education competencies and responsibilities. This remedial preparation would provide training in the basic competencies, upon which graduate-level preparation could then build. This training should address those areas where a student lacks competency-based preparation, following the guidelines articulated by AAHE/SOPHE. This attaining of the basic or entry-level standards helps to assure that all practitioners have a common set of skills. It is this set of competencies that the certification tests and verifies.

Implications of the Graduate Standards

There are two obvious implications for the adoption of graduate professional preparation standards. The first is to assure that, regardless of the school and program from which an individual graduates, there is a common core of preparation for practice upon which employers can rely. The more professional preparation is recognized as adhering to nationally acknowledged stan-

dards, the more health education will be recognized as a profession. This increases the marketability of each program's graduates. A secondary implication is that professional preparation programs will develop program curricula which include and are guided by the new areas of responsibilities and competencies that have been identified as appropriate at the graduate level. As standards are adopted, accrediting bodies (e.g., SABPAC, NCATE & CEPH) will use these standards in their review procedures. As these accrediting bodies incorporate the new standards into their expectations, programs and departments which prepare graduate health educations will align themselves with the new expectations. As interest in accreditation increases, those departments not preparing students in the basic graduate competencies may consider revision of their curricula to bring their programs in line with existing national standards.

Other possibilities exist which have to do with NCHEC and competency based assessment. It is possible that the advanced responsibilities and competencies could lead to a test designed to assess mastery. This might lead to the development of a second-tier certification.

Beyond the advanced-level assessment is a possibility that specialty examinations may be developed. Given the current division of health education practice into major settings (e.g., community, worksite, school, and medical care/patient education), and the continued interest in disease specific educators (e.g., HIV/AIDS Educators), NCHEC may, at some time in the future,work with subspecialties of the profession and their respective professional organizations, as well as professional preparation programs to develop specialty certifications. But this is for the future.

The profession of health education is at a juncture of unprecedented opportunity, in part defined by its own efforts to enhance the skills and abilities of the health education practitioner, but also in part by the dramatic changes that are occurring in the nation related to the organization, delivery, and payment of health services. The strength of the profession is in direct proportion to the

strength of the academically-prepared professionals who come from strong, competency-based programs. Using standards which have been validated by the profession to influence the curricula of such programs will only serve to strengthen the status of health education.

References

Bensley, L.B. and Pope, A.J. (1992). A self-study instrument for program review of graduate programs in health education. *Journal of Health Education, 23*(6), 344-346.

National Task Force on the Preparation and Practice of Health Educators. (1985). *A Framework for the Development of Competency-based Curricula for Entry-level Health Educators*. New York, NY: National Commission for Health Education Credentialing, Inc.

U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine (1991, February). *National Conference for Institutions Preparing Health Educators*. Birmingham, Alabama: DHHS Publication No. 81-50171.

U.S. Department of Health Education and Welfare, Health Resources Administration, Bureau of Health Manpower, Division of Allied Health Professions (1978, February). *Workshop on Commonalities and Differences in the Preparation and Practice of Health Educators*. Bethesda, Maryland: DHEW Publication No. (HRA) 78-71.

* *Members of Joint Committee listed alphabetically: E. Ames, D. Calitri, W. Cissell, P. Evans, A. Frazee, M. Hawkins, D. Hippler, M. Kittleson, W. Livingood, P. Mail, C. Peter, D. Read, R. Richards, J. Robinson, M. Smith, S. Stewart, and E. Vitello.*

CHAPTER 4

A CASE STUDY IN DEVELOPING STATE GUIDELINES FOR PREPARING UNDERGRADUATE AND GRADUATE HEALTH EDUCATORS

William B. Cissell, Ph.D., M.S.P.H., CHES

Professional health educators of Texas have long had an interest in basing the preparation of aspiring professional health educators on well developed and widely recognized standards. They have provided leadership both within their own state and nationally in the development of state-of-the-art curricula, designing and distributing frameworks and guidelines for curriculum development, and prodding officials in state agencies, professional organizations, and their home institutions into supporting efforts to assure quality in graduate preparation. The development of the *Guidelines for Health Education/Health Promotion Degree Programs in Texas* (Health Professions Education Advisory Committee [HPEAC], 1993) served as both a challenge and an opportunity for health educators wishing to influence professional preparation standards.

Background

For an extended period of time prior to 1978, aspiring health educators and physical educators in Texas were prepared in a common curriculum and received a common certification of their competence. After considerable pressure had been directed at the Texas Education Agency (TEA) and the Texas Higher Education Coordinating Board (CB) by both health educators and physical

educators, they authorized separate preparation and certification for these two disciplines (Buckner, 1995; Cady, 1995; Calsbeek, 1995; Hansma, 1995; HPEAC, 1993). Shortly after this was achieved, academic departments that prepared health educators began to broaden their foci to include preparation that would enhance the graduates' prospects for becoming employed in settings other than public schools (Cady, 1995; Calsbeek, 1995; Hansma, 1995).

In 1987, the Texas state legislature passed into law Senate Bill 994, which limited prospective public school teachers to a maximum of eighteen semester hours of professional education courses. The CB responded by prohibiting the awarding of undergraduate education degrees. An array of new names for undergraduate programs proliferated, which led to confusion on the parts of students, curriculum committees within the colleges and universities, the community, and, possibly most significantly, members of the HPEAC of the CB (1993). In September 1991, the HPEAC, in an effort to clarify the appropriate preparation standards for the discipline represented by terms including community health, health education, and health promotion, appointed The Health Education/ Health Promotion Task Force.

Rather than address all of the items listed in the initial charge presented to them by the HPEAC, members of the Task Force focused on the following:

1. Identify and recommend the minimum subject content and terminal competencies expected of graduates of baccalaureate, masters and doctoral degree programs for health education and health promotion.
2. Identify the entry-level degree for health education and health promotion professionals.
3. Identify educational ladders and avenues of educational mobility available for graduates of health education and health promotion degree programs.

More than two years were devoted to developing the recommendations in the final report, *Guidelines for Health Education/Health Promotion Degree Programs in Texas* (HPEAC, 1993).

Membership of the Task Force

Initially, the makeup of the Task Force caused grave concern among the professional health educators in Texas. The individual appointed to chair the Task Force was the dean of the University of Texas School of Public Health. The majority of the rest of the members were college and university administrators and staff of the CB who had neither been trained nor ever practiced as health educators. Only four members of the total of 19 Task Force members were employed as faculty in academic departments that prepared health educators. Two others were health educators employed in provider institutions. One of these was employed in the Texas Department of Health and the other was employed in a hospital.

Professional health educators began to communicate concern by telephone, correspondence, and visits during meetings of their professional organizations about a task force with the preponderance of its members being without health education credentials establishing standards for professional preparation in our field. A meeting sponsored by the Health Education in Higher Education Foundation focused on a review of issues and concerns about the membership of the Task Force, its charge, and strategies to assure acceptable outcomes of the process in which the Task Force was engaged. Individuals who had the greatest potential to influence them volunteered to assure that accurate information was presented to particular members of the Task Force, and they succeeded in doing so. Some volunteered to review and critique drafts of recommendations as these were distributed to members of the Task Force and they succeeded in doing so. Three volunteered to make presentations to the Task Force during one of its meetings. They were able to make presentations to the subcommittee of the Task

Force that was preparing the guidelines for preparation at the baccalaureate level.

The Finished Product

The guidelines are presented in a 36 page document, which includes title page, list of the members of the CB, table of contents, preface, charge, introduction, discussion of considerations about the feasibility of an associate degree preparation, baccalaureate degree guidelines, masters degree guidelines, doctoral degree guidelines, references, and appendices. The preface states a commitment by the CB to use the *Guidelines* as a standard against which to consider authorization of programs without regard to the names used in identifying them. It also indicates that the intention of the CB was to authorize programs that "...focus on educating students to assist in changing or reinforcing the behavior of individuals, organizations, and communities" (HPEAC, 1993 p. 1).

The introduction provides a very brief historical perspective of the field of health education. (See note *.) It emphasizes the need within a society for the services of health education professionals. It provides a sketchy overview of early preparation programs, the philosophy underlying health education practice and discussion of some of the content previously included in preparation programs. It also includes the definition of health promotion that was adopted by the World Health Organization and the American Public Health Association and states endorsements of the Role Delineation Project for Health Education and *A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators* (National Task Force for Preparation and Practice of Health Educators, Inc., 1985).

The Task Force recommends that the associate degree level not be accepted as the entry-level degree for health education. Rather, they recommend that students pursuing an associate degree seek to practice in another health-related occupation or use their associate degree coursework as an academic foundation for entering a baccalaureate program in health education.

The Task Force states eight specific curriculum guidelines for the baccalaureate degree. The first of these is that this be the first degree in the career ladder for professional health educators. It also recommends that, at this level, preparation should be general rather than specialized to a particular practice setting. Other recommendations address the issues of articulation of the general education requirements with the major curriculum, exit competencies, a balance between content and process skills, and the use of innovation and creativity in program design. The suggested curriculum design includes 60 semester hours devoted to general education competencies, 36 semester hours devoted to discipline program competencies, and 24 semester hours devoted to professional competencies. The specific competencies and outcomes are stated in considerable detail.

To determine competence to enter a masters degree program in health education, the Task Force recommends that the applicant be required to have completed a baccalaureate degree in health education or a baccalaureate degree in a related discipline, and (a) two years equivalent work-related experience and leveling coursework or transcript evaluation, (b) completion of prerequisite leveling coursework, or (c) transcript review for comparable or related coursework in other disciplines. Five areas of competence, including: 1) assessment and research, 2) program leadership, 3) program planning, 4) program implementation, and 5) program evaluation, were identified as the categories into which the competencies and outcomes at the masters level should fall.

The volume of courses necessary to achieve competence in the skills appropriate to this level of preparation was projected to fall in the range of 36 to 45 semester hours, after completion of prerequisites and leveling courses. Competence can be achieved in each of the categories through one or more individual courses or through units spread over several courses. Completion of an internship and a graduate-level project culminating in a thesis or professional paper is required.

The Task Force describes preparation at the doctoral level as "in a preliminary manner because the Task Force believes the

profession at this education level is in an embryonic stage and is still developing." (See note **.) The Task Force reports that core competencies at the doctoral level are not specified in the field of health education and that, for this reason, "the institutions would not be restricted in developing curricular elements to mirror the developing profession." It describes the primary purpose of the doctoral degree in higher education preparation as conducting research as a point of reference to guide the reviewer in critiquing a program. It also indicates that university teaching and program administration are important applications of the knowledge and skills appropriate to an individual educated at the doctoral level.

Eligibility to enter the doctoral level program is based on completion of "baccalaureate and master's preparation that may be in a variety of fields, such as physical education/ kinesiology, nutrition, education, allied health, physiology, psychology, public health, and nursing. Individuals having other than health education/health promotion undergraduate education would be required to achieve the equivalent of master's level preparation in the field prior to being admitted to doctoral level courses."

Five areas, 1) behavioral and social sciences; 2) epidemiology and biostatistics; 3) program planning, management, and evaluation; 4) human biological sciences; and 5) research methods, are designated as appropriate categories for the core competencies in a doctoral program.

Impact of Guidelines on Programs

Based upon recent correspondence and telephone conversations between this writer and present and former chairs and heads of professional preparation programs across Texas, the *Guidelines* have had almost no effect on graduate programs to date (Buckner, 1995; Calsbeek, 1995). This is not surprising since these were published and distributed less than two years ago. The majority of those expressing an opinion believe that the *Guidelines* will eventually have a slight effect on masters programs (Buckner, 1995; Cady, 1995; Calsbeek, 1995; Hansma, 1995). However, there is

little substance in the recommendations at the doctoral level, which means that virtually none of the three current doctoral degree programs in Texas is apt to be affected by the *Guidelines*. The greatest impact has been at the baccalaureate level and this is apt to be the case in the future.

Integration of Nationally Developed Graduate Standards

The Joint Committee on Graduate Standards, which is discussed in greater detail elsewhere in this monograph, has been working since 1992 to develop a recommended framework for curricula at the graduate level. This framework will be organized into areas of responsibility, competencies, and subcompetencies that include and supplement those resulting from the Role Delineation for Health Education Project. At this point, the Joint Committee has not developed a final document to recommend to its sponsoring organizations. Therefore, discussion of the integration of these standards into programs in Texas is highly speculative at best.

Based upon preliminary drafts that have been circulated to the field for review and comment, the future graduate standards will be highly likely to support and complement the *Guidelines* at the masters level. Whether or not they will be more directive than the *Guidelines* are at the doctoral level is difficult to predict.

Some of the academic departments that offer professional preparation in health education in Texas closely monitor developments at the national level. Most of these act quickly to integrate new guidelines and standards as well as inform their students of current issues and concerns affecting our field. Others tend to lag behind in the pattern commonly seen in diffusion of innovation models. If, and when, nationally produced and professionally endorsed graduate standards become available, the same pattern of integration is apt to occur. At least in Texas, there will be a reference document available through the CB that supports efforts to assure competence in appropriate skills and knowledge by the professionally prepared health educator.

Recommendations

The *Guidelines for Health Education/Health Promotion in Texas* (HPEAC, 1993) is a reference document that all chairs and heads of health education programs in higher education should have in their professional libraries. It will be useful for inspiring a higher education board or commission to examine current practices for assuring quality in the preparation of professional health educators where this seems desirable. It will also be a good supplement to the graduate standards that are being developed by the Joint Committee on Graduate Standards. The latter will probably be distributed in their final form in mid-to-late 1996. If the process of setting state or commonwealth standards follows the pattern seen in Texas, the preponderance of the members of the recommending body will be health professionals other than health education specialists. It will be important for the health education specialists to quickly organize to assure that the members of this recommending body are well versed on the appropriate standards. Further, leaders of heath education preparation programs should continually monitor the quality of their programs. Availing themselves of appropriate reference documents should be a routine activity.

* NOTE: The Task Force expresses a preference for the term ***health promotion***. This author prefers the term ***health education*** and uses it rather than health promotion in most circumstances.

** NOTE: Three universities in Texas have been awarding doctorates in health education for more than 25 years. One must ponder the length of time that a discipline must experience the embryonic stage of doctoral degree development.

References

Buckner, W. (1995, June). Telephone interview on the history of preparation of health education professional in Texas. Interview conducted by W. B. Cissell.

Cady, R. (1995, June). Telephone interview on the history of preparation of health education professionals in Texas. Interview conducted by W. B. Cissell.

Calsbeek, F. (1995, May). Letter responding to a request from W. B. Cissell for information on the history of preparation of health education professionals in Texas.

Hansma, J. (1995, May). Telephone interview on the history of preparation of health education professionals in Texas. Interview conducted by W. B. Cissell.

Health Professions Education Advisory Committee [HPEAC]. (1993). *Guidelines for Health Education/Health Promotion Degree Programs in Texas: A Report from the Health Professions Education Advisory Committee to the Texas Higher Education Coordinating Board*. Austin: Coordinating Board.

National Task Force for Preparation and Practice of Health Educators, Inc. (1985). *A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators*. New York: National Commission for Health Education Credentialing, Inc.

CHAPTER 5

EMPOWERING HEALTH EDUCATORS TO INTEGRATE COMPETENCIES INTO GRADUATE COURSE SYLLABI

Judy C. Drolet, Ph.D., CHES, FASHA
Evelyn Ames, Ph.D., CHES
Joyce V. Fetro, Ph.D., CHES, FASHA

Introduction

For over four decades health educators have examined competencies needed for professional practice. Initial attempts to identify these abilities for undergraduate training occurred at Jackson's Mill, West Virginia (1948). Graduate preparation was the focus of a similar meeting at Pere Marquette State Park, Illinois (1950). More recently, the National Task Force for the Preparation and Practice of Health Education (1985) (now the National Commission for Health Education Credentialing, Inc.) identified a Framework of seven generic areas of responsibility with 27 competencies and 79 sub-competencies for entry-level health educators (Foder, Dalis, & Giarratano, 1995). These responsibilities are applicable for work conducted in schools, colleges/universities, community, worksite, and medical settings with individuals, groups, and organizations. Since they are criteria for certifying health education specialists, these competencies also serve as a foundation for professional preparation and encouraging professional development.

During the past ten years, institutions that prepare health educators most frequently have infused these competencies into

courses such as *Evaluation, Community Organization,* and *Research Design*. Now integration also needs to occur or expand in courses typically identified as "content" and "methods" classes. In addition to "process" courses, course syllabi for "content"-oriented courses (e.g., sexuality education, chronic/degenerative disease, consumer health, substance abuse/drug prevention education), where usually less focus is placed on process and skills, need to incorporate entry-level responsibilities and competencies. For example, theoretical steps for program planning learned in *Community Organization* can be reinforced by an assignment in *Sexuality Education* to plan an in-service workshop on "disease-protected sex" for staff at the local county health department.

The National Council for Accreditation of Teacher Education (NCATE) adopted (September 1986) matrices that delineate the seven areas of responsibility and their accompanying competencies and sub-competencies for review to accredit teacher education programs in health education. University folios submitted for review for program approval are based on these areas as well as course content in health education and professional issues. Aside from teacher education, university health education programs may seek approval for the baccalaureate level program from the Society for Public Health Education and Association for the Advancement of Health Education Baccalaureate Program Approval Committee (SABPAC). The SABPAC manual targets achievement of skill in these same responsibilities, competencies, and sub-competencies.

In addition, the Joint Committee for the Development of Graduate Level Preparation Standards has drafted additional competencies for the seven responsibilities and additional areas of responsibilities and competencies related to the practice of health education such as research principles, management and supervision, and leadership skills including cognition of ethics. These additional areas of responsibility reflect classical components of professional preparation commonly addressed in graduate

curricula. [See Chapter Three that fully explains the work of the Joint Committee.]

University and college professionals need to re-examine their course syllabi to strengthen and enhance existing activities and strategies to make them more adequately address these program standards. Courses in which both undergraduate and graduate students enroll should indicate different standards for the respective levels. Authentic experiences that are relevant to the practitioner should be included within the structure of a course. Responsibilities can be included in syllabi by:

- building class activities to meet the competencies and sub-competencies
- providing functional information needed to accomplish sub-competencies
- constructing authentic assessments to evaluate level of accomplishment of the sub-competencies.

Examining and Strengthening Existing Syllabi

Although *all* delineated graduate standards will not necessarily be addressed in *every* "content," "methods," or "process" related course in a graduate program, all existing course syllabi should be systematically examined and strengthened to more adequately address established graduate standards and prepare students for real-life experiences in the field of health education. The following questions can guide this examination:

- *Does the proposed course content provide "functional" knowledge?*

Although one goal of "content" related courses might be to address the breadth and depth of information about a specific health topic, instructional time is limited. A series of lectures may provide comprehensive coverage of a particular health topic but specific facts are forgotten and/or become outdated over a period of time. Although attainment of health content expertise should

not be minimized, it is critical to provide students with "functional" knowledge - basic practical information, including how to obtain updated information based on current research and practice. Thus, examining multiple formal and informal sources of information about human sexuality as well as the potential validity and reliability of those sources would be more "functional" than memorizing specific facts about human sexuality.

- *Are the proposed instructional strategies skills-based?*

Instructional strategies can be divided into four categories: strategies for gathering key information (e.g., community organizations, current events, field trips, guest speakers, personal interviews, surveys, lecture, media), strategies for encouraging creative expression (e.g., creative writing, position papers, dramatic presentations, role plays), strategies for sharing thoughts, feelings, and opinions (e.g., brainstorming, continuum voting, delphi studies, forced field analysis, panel discussions, self-assessment, journal writing), and strategies for developing critical thinking (e.g., case studies, debates, media analysis, technical writing).

Instructional strategies should be varied, but more importantly, they should provide experiences for active learning, skill-building, and higher level thinking. For example, rather than presenting students with a list of community-based organizations that offer sexuality-related programs and services, selected students would be assigned to call or visit community-based agencies, interview staff, and then present a community resource map to other students.

- *Can student activities be restructured to more adequately address graduate standards and provide authentic experiences that prepare them as health education practitioners?*

Most course syllabi require completion of individual and/or group projects and student papers such as researching sexuality issues and reporting results in a class presentation. Whenever possible, assignments should be restructured to *apply* information and skills rather than merely present information. For example, after students review and evaluate existing sexuality education curricula for comprehensiveness and potential effectiveness, they

would make a recommendation to the district materials review committee for curriculum adoption with arguments for a specific curriculum adoption. Or, after investigating physical, social, emotional, and cultural influences on sexuality-related behavior, students can be asked to conduct a community needs assessment to determine program strategies for implementation.

Sexuality Education - Sample Syllabus

For purposes of this chapter, a *Sexuality Education* course syllabus is used as an example to demonstrate and guide faculty in incorporating health education responsibilities and competencies into course syllabi. Figure 1 includes descriptions of how competencies can be integrated into descriptions of course assignments and among syllabus topics in a class schedule.

Figure 1

Selected Sections from Sample Syllabus
Incorporating Responsibilities and Competencies

AUTHENTIC CREATIVITY UNIVERSITY
Department of Health Education

HED 405 SEXUALITY EDUCATION (3 cr) -- Fall 2001

Instructor: Carolyn S. Controversial, PhD, CHES

---

1. **Course Focus:** This course will address the knowledge and skills that are needed to address the complex issues of sexuality education. Discussion will include challenges and resources for all settings in which health educators practice: schools, university/college, community, worksite, medical. Class members will examine the "who, what, when, where, and how" of sexuality education. Emphasis is placed on developing the competencies essential for application in professional practice. Students are expected to come to class

having completed reading assignments and prepared to participate in course discussion and activities. Let's have a productive and fun semester!

2. **Course Objectives/Health Education Responsibilities:** In addition to the sexuality-related material examined in this course, you will participate in activities that prepare you for real-life experiences as a practicing health educator. [Competencies for performing tasks in work settings identified by the National Commission for Health Education Credentialing, Inc. are identified in parentheses.] At the completion of this course, you will be able to:

√ use formal and informal sources of sexuality-related information [I A 1,2, VI a 1]

√ investigate physical, social, emotional, and cultural influences on sexuality-related behavior [I B 1,2 III C 1]

√ plan and implement an age/developmentally appropriate sexuality education activity for designated student levels (K-12) [II C 2, D 1,3, III A 2,3

√ analyze media messages to identify underlying societal values and forces [VII B 1]

√ apply criteria for comprehensiveness and potential effectiveness to existing sexuality education curricula [II B 2 IV A 1, B 2,3]

√ present results of curricula evaluation to key decision makers [IV C 2,3 D 2, VII C 2]

√ determine the extent of sexuality-related materials, services, and resources and identify gaps and duplication in services [V A 1,3 C 2]

√ advocate for sexuality education programming in a local community [VII B 1, 2 C 1,2]

3. **Required texts:**

Sexuality Education Within Comprehensive School Health Education, American School Health Association, Kent, OH (1991) **Book A**

The Sexuality Education Challenge, Promoting Healthy Sexuality in Young People, J. Drolet & K. Clark (eds.), ETR Associates, Santa Cruz, CA (1994)
Book C

4. **Grading:** You will receive points for all work in this course. Final grades will be assessed from the following:

Exams I, II, Final Exam: Three exams will be given in this class. Each exam will cover the section of course material and readings designated in your course syllabus. A variety of question formats will be used: short-answer; fill-in-the-blank; multiple choice, matching. In each exam you will be asked to recall information as well as respond to situations in which you apply what you have learned. **50 pts ea**

Team Project Activity: In class you will be assigned to a group for an in-class presentation. Handouts with guidelines will be discussed in class. In general, you will be responsible for planning and implementing an age/ developmentally appropriate activity using the ASHA book for guidance about content and skills. In addition, after each group project is presented you will be asked to submit your quantitative and qualitative evaluation of the project. **30 pts**

Formal and Informal Sources:
Heritage and Cultural Values: On the date designated in your syllabus you should bring to class the computerized list of sexuality related reports on relevant risk behaviors and your personal "Heritage and Cultural Values" self-assessment (homework). We will investigate in large and small group discussions physical, emotional, intellectual, and social factors that influence sexual behaviors. **10 pts ea**

Media Analysis: Guidelines will be discussed in class for your assessment of the variety of purposes/values/images/roles/influences and so on of sexuality in mass media. Opposing social forces will be investigated. The impact of societal value systems on sexuality related programs will be predicted. **10 pts**

Research Journal Report: You will provide an oral summary of one sexuality related research article from a professional journal. Current APA style should be used for the citation of your article. A separate handout will provide details for this assignment. **15 pts**

Selecting Curricula: In class you will have opportunities to review and evaluate currently available published sexuality education curricula. After this "hands on" activity you will provide an assessment of their components. In a role play activity you will interpret your findings for a community advisory committee or school board meeting. **20 pts**

Reaction Papers: As we discuss various topics in this course you will be asked to write about your response to speakers, videos, reading assignments and so on. Your comments should be a critique and/or examination of how you would use the resource within sexuality education in a work setting of your choice. Further details will be discussed in class. **5 pts ea**

Follow the Leader: Chapters in your book focus on sexuality education in conservative communities; among high risk populations, and in religious organizations. Using the guidelines provided in class you and your partner will be "leaders" of a "campaign" to articulate your perspectives. Particular emphasis should be placed on application of ethical principles. **15 pts**

Coordinating Community Services: Guidelines will be provided in class for acquiring information about agencies that provide sexuality related materials, services, and other resources. You will be assigned a team with whom you will formulate a plan for coordinating services including identification of gaps and overlap in offerings. Identification of potential sources of conflict and methods for conflict management should be included in your program. **15 pts**

TENTATIVE COURSE SCHEDULE

Date	*Topic*	*Chapter*	*Assignment*
Ts, Aug 22	Introduction and Course Overview	C2, 5	Personal Info Sheet
	Review of K-12 Team Projects	ASHA book	Project Topic Sheet
Th, Aug 24	Historical Perspectives	C1	Reaction Paper - Yarber Scholar Address

TENTATIVE COURSE SCHEDULE (cont.)

Date	*Topic*	*Chapter*	*Assignment*
Ts, Aug 29	Politics and Policies: Why "Sex Ed"	C3	
Th, Aug 31	Back to the Basics: Biological Aspects	A	Bio sections
Ts, Sept 5	Sources of Sexuality Education	Handouts	Computer Sources
Th, Sept 7	Diversity and Sexuality Education: Cultural Competence; Gay Issues, Special Education	C18, 19, 20	Cultural Assessment
Ts, Sept 12	* continued *		
Th, Sept 14	Parents & Caregivers: Educators & Advocates	C26	
Ts, Sept 19	The Affective Dimension: Essential for Effectiveness	C14	Reaction Paper
Th, Sept 21	**EXAM I**		
Ts, Sept 26	Planning and Implementing Sexuality Education Programs	A1	
Th, Sept 28	Controversies and Challenges	C4, A4	
Ts, Oct 3	* continued *		
Th, Oct 5	Language and Communication about Sexuality	C15, A3	"Power of Words" in- class activity

TENTATIVE COURSE SCHEDULE (cont.)

Date	*Topic*	*Chapter*	*Assignment*
Ts, Oct 10	Team Activities: Pre-K: Grades 1 & 2	A5, 6	Project Evaluations
Th, Oct 12	Mass Media and Sexuality	C30	Media Analysis
Ts, Oct 17	Team Activities: Grades 3 & 4: Grades 5 & 6	A6	Project Evaluations
Th, Oct 19	HIV/AIDS Update; What Educators Need to Know	C16, A-Ap A	Reaction Paper
Ts, Oct 24	Community Programs and Partnerships	C23, 24, 25	"Follow the leader"
Th, Oct 26	**EXAM II**		
Ts, Oct 31	*** Semester Break ***		
Th, Nov 2	Avoiding "Getting Into Trouble"		In-class activity
Ts, Nov 7	Selecting Sexuality Education	C-Ap B	Curricula Assessment activity
Th, Nov 9	* continued *		
Ts, Nov 14	Evaluating Sexuality Education Programs	C31	In-class Assessment activity
Th, Nov 16	Team Activities: Middle School/ Junior High School	A7	Project Evaluations

TENTATIVE COURSE SCHEDULE (cont.)

Date	*Topic*	*Chapter*	*Assignment*
Ts, Nov 21	Research Issues, Studies, and Conclusions	C32, 33	Research Journal Article Report
Th, Nov 23	* continued *		
Ts, Nov 28	*** Thanksgiving Break ***		
Th, Nov 30	*** Thanksgiving Break ***		
Ts, Dec 5	Team Activities: High School	A8	Project Evaluations
Th, Dec 7	Coordinating Community Services		Team Plan/ Conflict Management

PLEASE NOTE: This class will meet at the scheduled Final Examination time: Ts, December 12, 2001; 5:50 - 7:50 p.m.

AUTHENTIC ASSESSMENT - Can We Apply What We Learn?

As revisions in course syllabi are made, instructors must identify opportunities to alter the methods used to determine if preparation in the responsibilities and competencies is occurring. Traditional formats such as multiple choice, matching, or fill-in-the-blank tests are narrow and limited in focus. They seldom focus on critical thinking, decision making, and goal setting. They require learners to recognize fragmented and isolated bits of information rather than to apply the information to exhibit

proficiency in complex reasoning skills. A more comprehensive measure of ways that students apply knowledge and skills as they might in the "real world" can be accomplished through *authentic assessment.* This means assessment tasks should be meaningful and representative of real-life performance expectations. The tasks more closely mirror instructional goals and the learning process. Thus, authentic assessment is a means of determining if students actually master the inherent skills that comprise the responsibilities and competencies delineated for health educators.

Rubrics, which offer clear performance targets to students and describe levels of performance, can be developed for specific tasks or situations that determine not only the minimum but the highest standards for performance. For example, when "Acting As a Resource Person in Health Education" a health educator would be expected to "use computerized health information retrieval systems effectively" to provide the county health department director with recent sexually transmitted disease rates.

In the *Sexuality Education* course, students would be assigned the task of conducting a search of current, accurate sources of these data. An example of a minimum standard would be that the student goes on line to obtain the latest data from their state department of health and submits a computerized printout of data showing age and gender comparisons of their county statistics. A high standard of performance would be that students use "CDC - Wonder" to obtain the latest data, develop graphs to illustrate changes over the past few years, obtain data to explain demographic data, and project future implications of the need for health education for the population groups most affected.

Or when "Planning Effective Health Education Programs" a health educator might "develop a logical scope and sequence for a health education program." In the *Sexuality Education* class, students would be assigned a group project to develop a K-6 scope and sequence of an age-appropriate sexuality education curriculum. The content of the course teaches "how to" accomplish this activity.

The assessment of the project would be:

- submission of a finished scope and sequence chart that includes clip art and use of word processing program

- submission of a reference list that includes a review of curricula for K-6 sexuality education curricula and program planning literature in health education

- identification of sexuality education interests and needs of young people in each grade level

- identification of community and parental needs and interests for their children's education about sexuality

- submission of a description page of the steps in the process that the group members went through to obtain information for planning and creating their proposal

- group presentation of their project information that includes visual aids (e.g., posters, bulletin board, and/or transparencies to educate their peers).

The process of revising a graduate level "content" or "methods" oriented course requires faculty to rethink the forms of assessment that they use to determine student outcomes. It means that faculty must literally discard tried and true evaluation tools such as multiple-choice and fill-in-the-blank types of tests. They must create assessments that encourage students to apply knowledge and skills gained in the course's learning activities. Guidance for this revision process comes from determining that the:

- proposed course content provides *functional* knowledge

- proposed instructional strategies are *skill*-based, and
- student activities are restructured to address graduate standards that apply to *authentic* experiences in which the health educator practices.

Reference

Foder, J.T., Dalis, G.T., Giarratano, S.C. (1995). *Health instruction: theory and application.* (5th ed.). Baltimore, MD: Williams & Wilkins Publishers.

77

CHAPTER 6

SELECTING A GRADUATE HEALTH EDUCATION PROGRAM TO MEET YOUR NEEDS

Mohammad R. Torabi, Ph.D., M.P.H., CHES

Introduction

This is an attempt to assist prospective graduate students in locating the most appropriate graduate health education program which will meet their needs. As a coordinator of graduate studies at Indiana University, I was invited to make a presentation on this topic at the annual meeting of Eta Sigma Gamma in Denver, Colorado. Since then I have received numerous requests for a copy of my talk. Publication of this article, hopefully, will provide students with some general ideas of where to begin.

Selecting a graduate education program will profoundly impact one's future professional career. It will stay with you for the rest of your life. Thus, careful and deliberate analysis of self interest and potential, as well as the prospective graduate education program, are worthy of serious consideration.

In this article the following topics are discussed: general considerations, academic considerations, financial considerations, search for the graduate program, criteria for the graduate program, strategies for contacting, and final thoughts.

GENERAL CONSIDERATIONS: Whether for personal or professional reasons, it is absolutely necessary to have short and long term goals. Without realistic and achievable goals in mind, one can go in circles. As Charles F. Kittering (Dale, 1984, p. 35) stated, "we should all be concerned about the future because this is where we will spend the remainder of our lives."

To establish professional goals, a prospective graduate student should conduct an objective self-assessment with regard to interests, potentials, strengths, and limitations. This step can be done with the assistance of your mentor, teacher, parents, or a trusted friend.

Based on these assessments, one should set up long-term goals. Having set the long-term goals, it is easier to establish short- term goals and objectives. Obviously, these short-term goals should be specific and have the potential to ultimately lead you toward the long-term career goal. This phase may require some time and a great deal of "soul searching." Often, I recommend to my prospective graduate students to seek short-term employment with health related professional agencies or expand their internships or volunteer for various public health organizations. Having different opportunities provides a prospective graduate student with relevant experience, time to think about career plans, and the possibility to become more financially secure in preparation for graduate school. During this time, one also can prepare to take the GRE (Graduate Record Exam), that is required by most health education graduate programs. My former graduate students who had p[illegible]ed for the examination tended to score higher than those who just took the test. Often, graduate admission committees tend to give more favorable consideration for graduate applicants with professional work experience and a high GRE score.

During this phase one can investigate the appropriate academic degrees needed to achieve his/her career goal.

ACADEMIC CONSIDERATIONS: Let's assume that a prospective graduate student is interested in pursuing a career in health education. It is important to see your short- term goals with regard to the desirable degrees such as M.S., M.P.H., M.S.P.H., or advanced degrees such as Doctor of Philosophy, Doctor of Public Health, Doctor of Health and Safety, or a Doctor of Education. Obviously, if one were interested in working at the grass roots level and serving as a practitioner, a master's degree is adequate.

However, if one's interest is in an academic or research career, a doctoral degree is very much needed.

It is also essential to develop an area of interest early in your career. The areas of interest may be content oriented such as drug education or methodologically oriented such as research design, assessment, evaluation, and statistics. This implies that one has a specific expertise in a certain area with a basic understanding of health issues in general.

FINANCIAL CONSIDERATIONS: Graduate schools are often more expensive than undergraduate schools. The range of annual tuition fees nationwide can vary from $6,000 to $21,000 a year depending on the major area, private or public, or in-state resident or out-of-state resident. To avoid becoming entangled in unmanageable debt and burden, one may benefit from following these simple steps (McWade, 1993):

Set Goals: Decide what you want to study, where you want to study, whether you want to study full-time or part-time, will you work to support all or some of your education, and what is your appropriate level of debt.

Take Inventory: Collect all your financial information (and that of any family member who will be contributing to your education). Subtract whatever you owe in debts and the amount you end up with is the amount you can contribute to your education.

Budget: Graduate schools are required to publish their standard budgets in their respective bulletins and publications. Once you receive this information, you know your school related costs. Then you create a budget for your personal costs. The total of these two determine your total cost for school.

Do an Analysis: Take the amount of budgets, subtract the amount you can contribute, and you know the amount you need in financial aid.

A point of interest regarding the availability of financial support may be in the form of a graduate teaching assistantship, graduate research assistantship, associate instructorship, or a fellowship. Often, major graduate health education programs offer the above financial assistance to graduate students, especially

doctoral students, and may include fee remission for tuition and an annual stipend that may vary from program to program. The fee remission component of a graduate assistantship is significant compensation for all graduate students, particularly the out-of-state and international students.

In addition to financial support, receiving a graduate assistantship award can provide students with long lasting and needed experiences. These experiences can vary from teaching, research, and possible publication. For instance, a graduate teaching assistant may have the opportunity of teaching or co-teaching a college course. The teaching experience may involve grading papers, tutoring, supervising lab work, and interacting with students. Working with seasoned scholars as a graduate assistant may provide you with hands on experience in conducting research projects including library searches, data collection, data analysis, data interpretation, and the write-up and publishing process of an article. Developing positive relationships with scholars and mentors will prepare students for future academic success. Furthermore, genuine cooperation with these researchers may lead to co-authoring and publishing articles.

Students who are interested in gaining research experience with certain faculty do not necessarily need to have a graduate teaching or research assistantship. Volunteering your services and expressing interest in working with certain faculty may open the door for other collaborations. Subsequently, as research grants and contracts become available to these faculty, one may have a better chance of being hired. Overall, it is highly recommended that graduate students, especially doctoral students, gain teaching and/or research experience by the time of graduation. These experiences, along with good recommendations from the faculty, will help you build your resume and, subsequently, make employment much easier in the competitive market.

SEARCH FOR THE GRADUATE PROGRAM: Based on your long term and short term career, academic, and financial goals, a prospective graduate student can search for an appropriate

graduate program. Some of the excellent sources for pursuing graduate health education degrees are listed below:

A. *A National Directory of College and University Health Education Programs and Faculties by Eta Sigma Gamma*, 1992 (also, 1995 edition in Press). This is a particularly important resource book and is available at any health education Department with Eta Sigma Gamma chapter affiliation. This document contains almost all of the health education departments in the United States. It is indexed by faculty names, states, and degrees offered. Most importantly, the document provides a prospective student with complete addresses, telephone numbers, and faculty degrees and areas of expertise.

B. Health Education Directory published by the Association for Advancement of Health Education entitled "*Directory of Institutions Offering Undergraduate and Graduate Degree Programs in Health Education.*" The latest edition was published in 1995.

C. *American Public Health Association Membership Directory*. This is also a valuable reference which covers general information about the American Public Health Association as well as listing members by addresses and primary interest areas.

D. "Guidelines for Selecting a Graduate Program in Health Education and Health Promotion," by Bensley, Gay, Pope, *The Eta Sigma Gamman*, Fall/Winter/86.

E. Professors, mentors, health education researchers, and health education officers of state, district, or national health education professional organizations.

F. Local library reference desk and selected titles of additional sources that are listed at the end of the articles.

G. Attending state, national, or international conferences. This is an excellent opportunity to meet faculty and learn about their respective programs.

H. Contacting major health education organizations often can answer one's general questions about the field or certain health education programs. Addresses and telephone numbers of these organizations are listed at the end of this article.

THE SEARCH FOR THE GRADUATE PROGRAM: Based on the following criteria it is important to gather and narrow down your list of selected universities.

Reputation of the University: It is important to mention that not every highly reputable university is reputable in health education.

Reputation of the Department of Health Education: The reputation of a health education department may be measured by considering numerous criteria such as the reputation of faculty conducting research, teaching, and in national leadership roles. For instance, a prospective student who is interested in an academic career should be more attracted to a health education department with these qualities.

The Alumni: The success of the department's alumni is also another indicator of the quality of the health education program. Through an informal conversation, one can learn a great deal about the faculty, students, and the program.

Grants and Contracts: Availability of research, education and service grants and contracts are another indicator of a successful health education department. Such grants and contracts often provide jobs and professional experience for graduate students.

Centers and Institutes Associated with the Department: Affiliation of centers and institutes with a health education department is another indication of the department's success within the university, and current and future success in procuring funds for research, training, and educational services.

Admissions Criteria: Different universities have different admission criteria. Major health education departments generally have reasonably similar admission criteria. They usually rely on past performance, which is the best indication of future success. They often are interested in students with high undergraduate or graduate grade point averages. Other criteria are high scores on the Graduate Record Exam (GRE), or the Miller's Analogy Test and strong letters of recommendation, especially from academic advisors and professors. For international students, high scores on the TOEFL examination are often a requirement. Sometimes a low score on one of the above criteria can be justified or compensated with documentation of the applicant's strengths in other areas such as related work experience or evidence of publications in professional journals. Prospective graduate students should examine these criteria very carefully when applying for admission to more than one institution.

Availability of Graduate Assistantships and Fellowships: Availability of assistantships may be a key criteria for certain graduate students because of absolute financial needs. If this is the case, the prospective graduate student should apply at least nine months in advance and clearly request an assistantship in his/her application documents.

Geographic Location: Geographic location should be an unimportant criterion. While it is ideal to be in a highly

desirable region, students should remind themselves that they are there only for a few years. Then after earning their degree and experience, they can be geographically selective for future employment.

It is worth mentioning that not all of the above criteria are equally important. For instance, not every reputable university has a highly reputable health education department. It is also possible to have a health education department in a smaller university. In my judgment, the most important criteria for a good academic unit is to have dedicated faculty who emphasize teaching and research. Teaching and research go hand and hand, especially in a graduate program. Usually the current students and alumni of the department can provide prospective graduate students with invaluable information about the program and the faculty.

STRATEGIES FOR CONTACTING: A prospective graduate student may solicit information and obtain an application in numerous ways:

- Send a letter of inquiry to the department or admissions office of the selected institution
- Make a telephone call to an individual faculty member or graduate coordinator
- Make an appointment and visit with a faculty member, graduate coordinator, department head, and selected students
- Visit the library, computer facilities, and the student services office of the institution

Based on the above initial fact finding, a prospective graduate student should target selected graduate programs and proceed with an application for admission consideration. It is important to start submitting the admission application about one year prior to the desirable date of starting graduate study. This allows a student

enough time for possible follow-up or appeal. Further, strong applicants admitted earlier are more likely to receive a graduate assistantship or fellowship. In my judgment, visiting the campus and meeting with selected graduate faculty increase chances of being admitted.

FINAL THOUGHTS: It is important that prospective graduate students think in long terms. Students must ask this question, "where can I get the best quality education that prepares me for a successful career?" Further, graduate education must include research experience for a student. A student whose career goal is working in an academic setting should select a university that provides him/her with strong research and teaching opportunities. Additionally, availability of obtaining professional service experience at a university should not be overlooked.

For the sake of long- term benefits, a prospective graduate student should tolerate a few inconveniences such as a six month or a year longer program, hardship of climate, geographical location, or a lower stipend. Most importantly, a graduate student must appreciate high academic demand.

Finally, I believe that no institution of higher education can provide a graduate student with high quality research and teaching experience for an uninterested and unmotivated student. Students should have a positive attitude and a desire to learn.

References

Bensley, L., Gay, J.E., Pope, A.J. (1986) Guidelines for Selecting a Graduate Program in Health Education and Health Promotion. *The Eta Sigma Gamman*, Fall/Winter, pp. 26-30.

Bensley, L.B., Pope, A.J. (1994) "A study of graduate bulletins to determine general information and graduation requirements for master's degree programs in health education," Unpublished paper.

Dale, E. (1984) *The Educator's Quotebook*, Phi Delta Kappa, Bloomington, IN.

McWade, P. (1993) *Financing Graduate School*, Princeton, NJ, Perterson's Guides..

Additional Sources

American Council on Education. (1994/1995). *Accredited institutions of post-secondary education, programs, candidates.* Washington: American Council on Education.

Barron's Educational Series. (1991). *Barron's profiles of American colleges*. Woodbury, NY: Barron's Educational Series.

Bear, John B. (1994). *Bear's guide to earning college degrees non-traditionally*. Benicia, CA: C&B.

Clark, Burton R. (1995). *Places of Inquiry: Research and advanced education in modern universities*. Berkley: University Press of California.

Educational Testing Service. (1993). *Directory of graduate programs*. Princeton, NJ: Educational Testing Service.

Doughty, Harold R. (1994). *Guide to American Graduate Schools*. New York: Penguin.

Gourman, Jack. (1993). *The Gourman Report: Rating of graduate and professional programs in American and international universities*. Los Angeles: National Education Standards.

Educational Testing Service. (1977). *Graduate and professional school opportunities for minority students*. Princeton, NJ: Educational Testing Service.

Higher Education Publications. (1995). *HEP higher education directory*. Washington: Higher Education Publications.

Kiger, Joseph C. Ed. (1982). *Quality in post-graduate education*. New York: Greenwood.

Ohles, John F., & Ohles, Shirley M. (1982). *Private colleges and universities*. Westport, CT: Greenwood.

Patterson's Educational Directories. (1995). *Patterson's American education*. Mount Prospect, IL: Educational Directories.

Peterson's Guides. (1995). *Peterson's gradline: computer file*. Newton Lower Falls, MA: Silver Platter Information.

Zuber-Skerritt, Ortun, & Ryan, Yoni, ed. (1994). *Quality in post-graduate education*. London: Kogan Page.

Addresses and Telephone Numbers of Major National Honorary and Health Education Professional Associations

American Public Health Association
1015 15th Street, N.W.
Washington, DC 20005
(202) 789-5600

American School Health Association
P.O. Box 708
Kent, OH 44240
(216) 678-1601

Association for Advancement of Health Education
1900 Association Dr.
Reston, VA 22091
(703) 476-3437

Eta Sigma Gamma
2000 University Ave.
Ball State University
Muncie, IN 47306
(317) 285-2258

Society for Public Health Education
2001 Addison Street, Suite 220
Berkley, CA 94704
(510) 644-9242

CHAPTER 7

HEALTH EDUCATION THEORY: A FOUNDATION FOR GRADUATE EDUCATION

Kathleen J. Welshimer, Ph.D., M.S.P.H.

Health educators' dynamic professional environment requires them to adapt rapidly to changing problems, priorities, and populations in a wide range of work settings. It is not possible for health education students to learn specific program strategies that anticipate every challenge. Fortunately, health education theory provides a framework for decision making and program planning that transcends particular work settings or service populations.

Whether health educators want to inform, motivate, facilitate or reinforce health-relevant behavior, health education theory can expand their understanding of health-related behaviors and problems, and strengthen their ability to offer effective programs. Furthermore, by testing and refining theory through its application to health education practice, health educators can strengthen the profession's intellectual foundation. This paper describes the nature of theory, its application to health education practice and research, and strategies for teaching and learning health education theory in graduate education. While many of the points apply to undergraduate students as well, they are usually exposed to theory at a basic, purely applied level.

The Meaning of Theory

Theory is defined as:

> Systematically organized knowledge applicable in a relatively wide variety of circum-

> stances... devised to analyze, predict, or otherwise explain the nature or behavior of a specified set of phenomena. (Webster's II New Riverside University Dictionary, 1984)

A theory describes the major factors that contribute to the phenomenon or behavior of interest, the relationships among these factors, and the conditions under which the relationships apply. To qualify as a theory, it must be generalizable across populations, place, and time. The factors and their relationships are quantifiable: they can be entered into a mathematical equation to predict or explain an outcome's occurrence. (Kerlinger, 1973)

Health education draws its theory from education, health and social psychology, and sociology. Much of the theory used in the discipline consists of "models." The Health Belief Model (Janz & Becker, 1984), PRECEDE/PROCEED Model (Green & Kreuter, 1991), and the Transtheoretical Model (Prochaska, DiClemente & Norcross, 1992) are three commonly used models. Like most models, they are derived from existing theory, applying theoretical concepts in a new way. Models are less specific than theory about the precise nature of relationships among the relevant factors. Nevertheless, they are as useful as full-grown theories for most program planning and evaluation purposes.

Benefits of Theory in Graduate Health Education

Health education theory can contribute to graduate education in several ways. It provides coherence to course work and helps students conceptually organize apparently unrelated information. For future practitioners, theory furnishes a framework for developing sound health education efforts. For future faculty and health education researchers, theory provides the solid grounding needed to contribute systematically to the profession's intellectual base.

Graduate students often feel that their academic preparation is compartmentalized into various areas of content (drug and alcohol education, sexuality education, etc.) and process (planning,

organizing, evaluation, research). The common themes connecting the content areas are not readily apparent, and how to apply the processes and strategies learned is often unclear. Consequently, students often characterize their graduate education as "too theoretical" when, in reality, their programs (particularly at the masters level) tend to be almost entirely atheoretical.

Learning theory has been compared to using a guidebook to a new city: once travelers learn the main streets and key landmarks, they find it much easier to navigate the city without becoming lost. When students are introduced to theory as a foundation for their educational experience, they can use it to organize what they have learned in various classes and bring coherence to their course of study. For example, students find that the Theory of Reasoned Action (Ajzen, 1991; Ajzen & Fishbein, 1980), which describes the influence of attitudes and social norms on behavioral intentions, helps identify considerations that are important to drug and alcohol use, sexual behavior, cardiovascular disease prevention, and other health issues. Knowing the Theory of Reasoned Action therefore facilitates learning and retention of themes from diverse content areas. Perhaps even more important, instead of viewing alcohol use, sexual behavior, and cardiovascular disease prevention as mutually exclusive problems, students become aware of principles that underlie various kinds of health-relevant behavior and understand that similar program strategies may be effective for different problems.

Similarly, a basic foundation in theory brings coherence to students' professional preparation or "process" courses. For example, students working with the Health Belief Model or the Transtheoretical Model quickly recognize their usefulness as a frame of reference for needs assessment, program planning, and evaluation of prevention education.

Health education relies on its researchers to refine and strengthen the intellectual base of the profession. There is still much to be learned about the most effective strategies for informing, motivating, and helping people to adopt and maintain healthy lifestyles. It is essential that future researchers be well trained in

educational, psychosocial, and behavior change theory and be able to use theory with confidence in their research. Educators of graduate students must help them value theory's practical utility, teach them major theoretical principles and their application, and impress upon them that applying and refining theory are important professional contributions. In this way, the profession's intellectual base, effectiveness, and credibility can be enhanced.

Benefits of Theory for Future Practitioners

The application of theory encourages systematic assessment, planning, and evaluation efforts, and helps ensure that the program produces maximum impact with fewest resources. By using a particular theoretical perspective or blend of theories to inform their health education program, practitioners can focus needs assessment on the most important needs and characteristics of their target population. At the planning stage, a theoretical framework enables them to design a program suitable to the particular population and setting, including the best strategies, messages, and sequence of activities. For evaluation, the theoretical framework enables practitioners to identify what factors and program elements to evaluate. It also enables them to examine the "hows" and "whys" the program worked as it did, and thus prepares them to refine their program for future use.

To illustrate, Social Cognitive Theory (Bandura, 1986), which characterizes the process of learning and carrying out new behaviors, might be used to design a program to promote condom use for prevention of HIV/AIDS. The theory suggests a variety of factors to address in the program: knowledge of HIV/AIDS and condom use, skill at using condoms, skill at negotiating about condom use in sexual relationships, sense of personal efficacy at using condoms and negotiating their use in relationships, people's beliefs about whether condom use will produce the desired HIV/AIDS risk reduction benefits, and how important they believe those benefits to be. The program's specific emphasis would depend on which of these elements the needs assessment finds to

be most problematic for the target group. To evaluate, the elements covered in the program would be measured before and after the intervention, and the program's impact on various subgroups of the population could be assessed. Thus, theory can help practitioners understand why people behave in a particular way, how to influence their behavior, and what factors to consider when evaluating a program's impact.

Limitations of Theory in Graduate Education

Faculty and graduate students can improve the way they teach and study theory by being aware of theory's perceived shortcomings and practical limitations. Many practitioners would not agree with the widely quoted assertion that "there is nothing as practical as a good theory." A recent study (Burdine & McLeroy, 1992) found that community health educators felt behavioral theory was interesting but not essential for practice. Health educators reported that theory is too abstract to be useful, and too rigid to meet their specific problems and practical realities. They also reported that they were troubled by the array of theories available. If the profession is to be enhanced through the effective use of theory, faculty must do a better job of illustrating its value to future practitioners and academics.

Making Theory Practical

The challenge for health education faculty is how to make theory practical. The recommendations that follow are based on faculty experiences, observations of students and practitioners, and the work of Van Ryn & Heaney (1992). It is appropriate to infuse theory into various content and professional preparation or "process" courses, rather restricting it to a single "Theory" or "Foundations" class. In some health education departments, a common core of theory is taught across the curriculum. For example, the Theory of Reasoned Action and/or the Health Belief Model, along with the Transtheoretical Model of behavior change, and Social

Cognitive Theory might be used. These theories provide a broad theoretical base for organizing course content and demonstrating common constructs that underlie various kinds of human behavior. The PRECEDE/ PROCEED Model provides another excellent theoretical foundation because it identifies social, behavioral, and environmental considerations in health education programming within the context of needs assessment, planning, evaluation, and community organizing activities.

Health education theory courses should focus on both the elements of theories and their application to health education situations. It is useful to begin with specific health education problems, then consider which theories can best contribute to students' understanding of the problem and its solution. Specifically, students consider what theories are most appropriate, given the population and setting of interest, then examine possible avenues of intervention suggested by these theories. For example, the problem of encouraging women to breast feed their infants might lead to consideration of the Theory of Reasoned Action, which characterizes the relative contributions of beliefs about performing a behavior and social norms, plus the Social Cognitive Theory, which describes various modes of learning as well as the role of self-efficacy. By applying both theories to the breast-feeding problem, students are able to grasp how similar elements are approached from different perspectives, and can recognize each perspective's unique contribution to a successful intervention. Van Ryn and Heaney's article, "What's the Use of Theory" (1992), offers additional guidelines for the process of selecting an appropriate theory and applying it to the various stages of program planning and implementation.

Organizing a theory course around application of theory addresses several of the limitations mentioned earlier. It teaches students the practical application of theory so they come to value its utility and flexibility. It trains them how to select a suitable theoretical approach for a particular health education problem. Finally, it shows students how to combine elements of several theories for effective programming. This process also draws on

students' existing knowledge of various content areas and helps them integrate theory and content.

Another important strategy for making theory more real to graduate students is to encourage them to conduct thesis and dissertation research that builds, tests, or applies theory to practice problems. The use of theory encourages systematic thinking as they consider variables and their relationships. This systematic approach has the important benefit of reassuring them that they have not overlooked critical elements in their understanding of the phenomenon or problem of interest. Even without being required to conduct theory-informed graduate research, students with a theoretical background are often intrigued by a particular theory's limitations and/or utility for studying various health-related phenomena and are stimulated to use a theoretical framework to organize or drive their research. Theory-informed student research also provides an opportunity to practice using theory under the guidance and encouragement of faculty. Finally, it reinforces the message that applying and refining theory is an important professional and intellectual contribution.

It seems reasonable to provide students with theories that span individual learning and skill building, small group behavior, community and organizational behavior, and large-scale change issues such as communication theory and diffusion of innovation. It is useful for students to learn the historic roots shared by many of these theories, the relationships among them, their similarities, and differences. Students use this information to mentally organize the theories they learn into a more coherent whole.

The readings used to study theory are also important. The perception that theory is too abstract may stem, in part, from the reading materials used. The educational and sociobehavioral literature features articles on theory testing, usually in rigidly controlled situations far from health education. Several basic texts appropriate to health education are now available (Glanz, Lewis & Rimer, 1990; Gochman, 1988; Stroebe & Stroebe, 1995), and the major health education journals increasingly publish research and evaluation studies testing and applying theory.

Student Efforts

Graduate students can acquire a foundation in health education theory even in programs where little theory is taught, since the books and journals described above are comprehensible without formal classroom training. In addition, students are encouraged to ask their professors to explain how the phenomena presented in class relate to the theoretical principles they have studied. Faculty may not have a ready answer, but student interest should stimulate them to consider the integration of theory with the content and processes they teach. Conversely, teachers of theory may overlook its application, in which case students should challenge them to make their material more practical. Students should get into the habit of synthesizing material from professional preparation and content classes with what they are learning about theory. In field opportunities and special projects, they should be encouraged to do the same.

Synthesis may not require conscious effort. Graduate students often report that studying health education theory raises their awareness about patterns of phenomena in the real world, and they find themselves automatically applying it to their everyday observations and activities. Students should also develop their own macro-models of the relationships among the various theories. This will reduce their complexity, help provide coherence, and will make them more manageable to use in both health education practice and test situations.

Conclusion

Burdine and McLeroy (1992) compare the use of theory to driving a car with a manual transmission. Initially, gear shifting takes much care and concentration, but eventually becomes so habitual that the driver is virtually unaware of the stick shift. This should be the goal of teaching theory to graduate students. If students acquire a solid preparation in theory and learn to think in the systematic fashion that theory encourages, the use of theory

will become second-nature in their research and practice activities. This is a worthy challenge for graduate faculty and a worthy objective for students, because a firm foundation in theory and its application enhances the professional practice of health educators, and strengthens the intellectual base and credibility of the profession.

References

Ajzen, I. & Fishbein, M. (1980). *Understanding Attitudes and Predicting Behavior*. Englewood Cliffs, NJ: Prentice-Hall.

Ajzen, I. (1991) The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*, 179-211.

Bandura, A (1986). *Social Foundations of Thought and Action*. Englewood Cliffs, NJ, Prentice-Hall, 1986.

Burdine, J.N. & McLeroy, K.R. (1992). Practitioners' use of theory: examples from a workgroup. *Health Education Quarterly, 19*(3), 331-340.

Glanz, K., Lewis, F.M., Rimer, B.K. (eds.). (1990). *Health Behavior and Health Education*. San Francisco, CA: Jossey-Bass.

Gochman, D.S. (1988) *Health Behavior: Emerging Research Perspectives*. NY: Plenum.

Green, L.W. & Kreuter, M.W. (1991). *Health Promotion Planning* (2nd Ed.). Mountain View, CA: Mayfield Publishing Company.

Janz, N.K. & Becker, M.H. (1984). The Health Belief Model: A decade later. *Health Education Quarterly, 11*(1), 1-47.

Kerlinger, F.N. (1973). *Foundations of Behavioral Research* (2nd ed.). NY: Holt, Rinehart and Winston.

Prochaska, J.J., DiClemente, C.C., Norcross, J.C. (1992). In search of how people change: applications to addictive behaviors. *American Psychologist, 47*(9):1102-1114.

Stroebe, W. & Stroebe M.S. (1995). *Social Psychology and Health*. Pacific Grove, CA: Brooks/Cole Publishing Company.

Van Ryn, M. & Heaney, C.A. (1992). What's the use of theory? *Health Education Quarterly, 19*(3), 315-329.

Webster's II New Riverside University Dictionary. (1984). Boston, MA: Riverside Publishing Company.

CHAPTER 8

ETHICAL DILEMMAS IN RELATIONSHIPS BETWEEN PROFESSORS AND STUDENTS IN GRADUATE EDUCATION

Teresa Pennington Hardman, Ph.D.

Introduction

The philosophical term "ethics" is derived from the Greek word, ethos, which means character or custom. Philosophers have struggled for centuries to define the term "ethics" and its application to individuals, organizations, and societies (Barry, 1984; Beauchamp & Walters, 1989).

Ethical issues in graduate education have been excellently discussed in the literature since the late 1970s. These discussions have emphasized ethical accountability and responsibility for both the graduate student and the graduate professor (Barger & Mayo-Chamberlain, 1983; Beauchamp & Childers, 1979; Bok, 1982, Brown & Krager, 1985).

Similarly, discussion of ethical issues, as applied to the professional practice of health education, have been ongoing since the 1950s. Many of these discussions have focused on ethical issue practices for the profession as a whole (Balog, 1985; Barnes, Fors, & Decker, 1980; Clark, 1983; Gold & Greenberg, 1992; Gutierrez & Shirreffs, 1985; Hochbaum, 1980; Klienschmidt & Ziman, 1953; McLeroy, Bibeau, & McConnell, 1993; SOPHE, 1983). Increasingly, attention has focused on ethics in the preparation of health educators (Drass & Feldman, 1989; National Task Force, 1985; Odom, 1988; Patterson & Vitello, 1993). The relationship between the graduate student and the graduate professor is

at the heart of professional preparation and, as such, is a pivotal component for ethical considerations.

Definition of Ethics

Ethics is a philosophical relationship or guide between and among people as they seek to interact with each other based on some system of rightness or wrongness (Barry, 1984; Beauchamp & Walters, 1989). For some, this system of rightness or wrongness is predicated solely on the consequences of the action. That is, if the consequence is harmful, then the action was ethically wrong. And vice versa, if the consequence of the action is good, then the action was ethically right (Balog, 1985; Harron, Burnside, & Beauchamp, 1983; Robson, 1966). For others, the ethical rightness or wrongness of an action is predicated on following rigid rules regardless of consequences. That is, a sense of duty selects the action, and consequences (good or bad) are not considered when choosing the action (Beauchamp & Walters, 1989; Munson, 1988).

Ethical Principles

Ethical principles represent general truths or doctrines that arise from a personal ethical belief system (Francoeur, 1983). Autonomy, beneficence, confidentiality, fidelity, justice, nonmaleficence, privacy, paternalism, professional accountability, utility, and veracity have long been discussed and delineated in the literature as specific principles of ethics (Munson, 1988). The principles of autonomy, beneficence/maleficence, justice, and professional accountability as they impact the graduate student/graduate professor relationship are the focus of this paper.

Autonomy is the ability of an individual to freely choose a course of action and its resulting consequences (Beauchamp & Walters, 1983; Hochbaum, 1980). Beneficence is concerned with increasing or promoting the welfare of others while maleficence refers to actions that bring harm to another (Beauchamp & Walters, 1989; Munson, 1988). The principle of justice embodies the

concept of equal and fair treatment (Beauchamp & Walters, 1989). Finally, professional accountability is defined as responsibility and accountability for consequences that result from individual professional practice (Patterson & Vitello, 1993; SOPHE, 1983).

Ethical Dilemma

Ethical dilemmas are situations in which two or more conflicting ethical principles may apply. Each may be a valid principle, but a choice must be made and that ethical choice will influence the outcome of the situation (Gold & Greenberg, 1992). The relationship between graduate student and graduate professor provides fertile ground for ethical dilemmas to occur as each person in the relationship acts from an independent, unique ethical frame of reference.

Professor/Student Relationship

The model relationship between professor and student is one characterized by sharing, mutual growth, and mutual benefit. As advocated by Bargar and Mayo-Chamberlain (1983), the premise of the relationship is built on the congruent and equal sharing of the ethical responsibilities in the relationship by both the graduate student and the professor.

Within this unique relationship of professor/student, a variety of roles are enacted. The professor may be advisor, committee member or chairperson, teacher, graduate assistant supervisor, mentor, colleague, and so forth. The student functions in the mirror image of each of the professor roles: that is, advisee, student, graduate assistant, mentee, collaborator, and so forth. Each role involves differing degrees of professional accountability and responsibility.

For example, both student and professor accountability and responsibility expectations with accompanying potential consequences are probably perceived to be greater in a professor's role as a committee chairperson versus that of committee member or in

the mentor role versus the advisor role. The interaction pattern in the chairperson and/or mentor role is expected to be upward, downward, lateral, broad in scope, inclusive, and visionary. These attributes can be compared to the more sequential, task-oriented functions of the committee member or advisor. With so many varying roles and levels of accountability and responsibility within each role, ethical dilemmas are certain to occur.

Potential Professor/Student Ethical Dilemmas

Recalling that an ethical dilemma occurs when a choice must be made between two valid ethical principles which are in conflict (Gold & Greenberg, 1992), let's briefly review two, of a myriad, of potential dilemma areas for the professor/student relationship that can serve as examples of ethical pitfalls in the relationship.

Specific Coursework. Brown and Krager (1985) suggest that an ethical advisor would allow the student flexibility in course selection (autonomy) without unreasonable rules and demands (nonmaleficence) while building on the student's competence and self insight (beneficence) and providing the student with adequate information and time (justice). One potential dilemma in this scenario is a conflict between autonomy and beneficence. What if the student only wants to take coursework that addresses personal strengths without regard to building up identified personal weaknesses? Or, what if a student places high value on personal time with family and friends and therefore chooses easier coursework that requires less time commitment? From the professor's viewpoint, which should win out - autonomy (freedom of choice) or beneficence (improving the welfare of another)? Would maleficence occur if the student is pressured into taking difficult coursework without regard to time constraints?

Research and Publication. Certainly, the area of research and publication has great potential for ethical dilemma in the professor/student relationship. Is the student involved in conceptual research tasks, not just menial task--nonmaleficence? Is the student afforded opportunities to participate in research and publication -

beneficence? Is fair recognition given to student and professor alike - justice? (Brown and Krager, 1985). What if the student contributes more than fifty percent of the work but the professor needs publications for tenure and the student is listed as second or third author or not at all? Is the student treated as slave labor (maleficence) or a collaborating colleague (beneficence)?

Role of Professional Accountability

What impact does the principle of professional accountability have on the potential ethical dilemmas between the professor and student in graduate education? The impact is powerful. The acceptance or rejection of professional responsibility and accountability for consequences resulting from the individual practice of health education affects ethical choices with regard to other ethical principles of autonomy, beneficence, justice , and others. If both student and professor own professional accountability, then the ideal relationship of mutual respect, sharing, and growth is more likely to occur. In the mutually shared climate of professional accountability, both student and professor can envision their individual roles in a holistic view of the profession. In this holistic view, it does matter whether the individual professor or student is ethical for the individual contribution affects the fabric of the profession, as a whole.

Summary

Graduate education is very time intensive with a concentration of one-on-one interaction between the professor and the graduate student. The sum of what's happening in this unique relationship is much more than an exchange of information. The student is "becoming" a professional, and the professor is "modeling" and "handing off" a mantle of professionalism for the student to grow into. This "becoming" is built not on a one-time lightning bolt experience but rather is made up of moments stacked one upon the other. We must not discount the moments, for it is in the

moments that we weave the cloth of the professional mantle. The irony is that we can only pass on what we have received in our own professional preparation. When ethical shortcuts are taken by either professor or student, the configuration of these moments is changed and the resulting professional mantle is altered. The principle of professional accountability can foster the growth process of both individuals and the profession as students and professors strive together to produce a professional mantle that majestically encompasses the best of each contributor as well as established ethical principles of interaction.

The author gratefully acknowledges the contribution of Elaine M. Vitello, PhD, in the conceptualization of this article.

References

Balog, J.E. (1985). Ethics and the field of health education. *The Eta Sigma Gamma Monograph Series, 4*(1), 63-110.

Bargar, R.R. & Mayo-Chamberlain, J. (1983). Adviser and advisee issues in doctoral education. *Journal of Higher Education, 54*, 407-432.

Barnes, S.E., Fors, S.W. & Decker, W.H. (1980). Ethical issues in health education. *Health Education, 11*(2), 7-9.

Barry, V. (1984). Values, ethics, justification. In T.R. Vallence (Ed.), *Values and ethics in human development professions*. Dubuque, Iowa: Kendall/Hunt Publishing Company.

Beauchamp, T.L. & Walters, L. (1989). *Contemporary issues in bioethics*. (3rd ed.). California: Wadsworth Publishing Company, Inc.

Bok, D. (1982). *Beyond the ivory tower*. Cambridge: Harvard University Press.

Brown, D. & Krager, L. (1985). Ethical issues in graduate education. *Journal of Higher Education, 56*(4), 403-417.

Clark, K.R. (1983). The implications of developing a profession-wide code of ethics. *Health Education Quarterly, 10*(2), 120-125.

Drass, J.A. & Feldman, R.H. (1989). Professional preparation of health education students: Results of an ethics training survey. *Wellness Perspectives: Research, theory and practice, 6*(2), 61-76.

Francoeur, R.T. (1983). *Biomedical ethics - A guide to decision making.* New York: John Wiley & Sons.

Gold, R. & Greenberg, J. (1992). *The health education ethics book.* Dubuque, Iowa: Wm. C. Brown.

Gutierrez, R.D. & Shirreffs, J.H. (1985). Is it right? An inquiry into health education ethics. *The Eta Sigma Gamman Monograph Series, 4*, 86-94.

Harron, F., Burnside, J., and Beauchamp. T.L. (1983). *Health and human values - A guide to making your own decision.* New Haven: Yale University Press.

Hochbaum, G.M. (1980). Ethical dilemmas in health education. *Health Education, 11*, 4-5.

Kleinschmidt, H.E. & Zimand, S. (1953). *Public health education: Its tools and procedures.* New York: The MacMillan Company.

McLeroy, K.R., Bibeau, D.L., & McConnell, T.C. (1993). Ethical issues in health education and health promotion: Challenges for the profession. *Journal of Health Education, 24*(5), 313-318.

Munson, R. *Intervention and reflection - Basic issues in medical ethics* (3rd ed.). Belmont, CA: Wadsworth Publishing Company.

National Task Force on the Preparation and Practice of Health Educators, Inc. (1985). *A framework for the development of competency-based curricula for entry level health educators.* New York.

Odom, J.G. (1988). The status of ethics instruction in the health education curriculum. *Health Education, 19*, 9-12.

Patterson, S.M. & Vitello, E.M. (1993). Ethics in health education: The need to include a model course in professional preparation programs. *Journal of Health Education, 24*(4), 239-244.

Robson, J.M. (Ed.). (1966). *John Staurt Mill - A selection of his works*. New York: The Odyssey Press.

Society for Public Health Education, (1983). Code of ethics. San Francisco: Society for Public Health Education.

CHAPTER 9

GRADUATE PREPARATION IN PHD PROGRAMS: SECURING A POSITION IN HIGHER EDUCATION

Sheila M. Patterson, Ph.D., CHES

The primary purpose of this paper is to explain some generic steps relevant to searching for a position in higher education. As part of the job search, options for improving your marketability while still in graduate school are detailed. Suggestions for the development of a curriculum vita, hints for writing a cover letter, as well as an overview of potential interview questions, are provided. Finally, suggested tips for maximizing the pre-tenure years are discussed.

Developing a Sense of Professionalism in Graduate School

Perhaps one of the areas where new Ph.D.s can gain an edge in the job market is to get an early start in developing your marketability for such a position. Webster's Dictionary (1993) defines professionalism as "the conduct, aims or qualities that characterize or mark a profession or a professional person" (p. 930). Three main categories of a position in higher education, regardless of discipline, focus around teaching, service, and research. There are a number of areas where people can strengthen their qualities in each of these three tenets while still in graduate school. Involvement in professional associations can be a first step for each of these areas.

Health educators have a variety of choices when choosing professional memberships. Among those directly related to health education are American School Health Association (ASHA),

American Public Health Association (APHA), Association for the Advancement of Health Education (AAHE), and the Society for Public Health Education (SOPHE), in addition to the academic honorary, Eta Sigma Gamma. Each association has a variety of membership levels (national, regional, state, or chapter) where graduate students can become involved. The primary method of involvement can be as simple as attending a state/national conference. In addition to attending worthwhile programs on teaching techniques and conducting research, each association also provides social/networking opportunities and committees where graduate students can volunteer and begin to get an appreciation of the service component. Although funds are often limited while attending graduate school (many associations give discounts on membership and conference registration to students), attending national conferences can provide a long term investment. If you make a commitment to meet and talk (not just introductions!) to one new professional at each national conference throughout graduate school, you will have the beginning of a professional network of colleagues when you secure your first position in higher education. Additionally, this network of new acquaintances and colleagues can be a wealth of advice during job searches, joining committees in the professional associations and perhaps even future collaborators in research. A new initiative by AAHE is aimed specifically at identifying graduate students with leadership potential in health education as well as AAHE itself. Leadership Associates Program (LAP) is an eighteen month program that provides leadership training, observing the governance structure by attending Board Of Directors meetings and becoming a member of one committee.

How will activities in professional associations help my marketability? New faculty members often are given the difficult task of juggling new courses, advising students, serving on committees while also conducting research and participating in scholarly growth activities. Candidates who apply for a position with an established professional network and evidence of balancing a number of priorities already have shown a mark of professionalism, the ability to manage shifting priorities, and a sense of the

efforts needed to be successful in higher education. Professional associations provide forums for sharing teaching strategies, improving, and sharing research techniques and becoming involved in the direction of the professional association. As a new faculty member, you may be asked to prepare a self-study on your school health education program to submit to the National Council for Accreditation of Teacher Education (NCATE) or prepare a self-study in your community health program for the SOPHE/AAHE approval process. Learning about these processes and attending a training session while a graduate student certainly would provide valuable assistance to the department/institution that hires you. Additionally, an awareness and understanding of these processes can aid in your knowledge of curriculum development and course revisions. In addition to the professional associations, leadership as an officer in an Eta Sigma Gamma Chapter, student government, community agencies, and task forces also lend credence that you are able to effectively manage time and function as a team player--essential qualities for all faculty in higher education.

The Search for a Job in Higher Education

The preliminary/qualifying examinations are over, all courses are completed or nearly completed and your dissertation is nearing completion. As tempting as it is to enjoy some moments of tranquility, you now need to start your job search. For higher education settings, the prime publication to search is *The Chronicle of Higher Education*, a weekly publication focusing on issues affecting higher education and also available in electronic form. In addition to the listing of positions in higher education, this should become a part of your professional reading prior to the job search. Reviewing each issue will provide you with a snapshot of emerging issues in higher education. A question often asked of job candidates may be similar to "What do you think are the top three issues facing higher education today?" In addition to joining a faculty within a specialized profession (health education), you also will be joining a campus community facing unique challenges and re-

wards, being cognizant of some of these issues will show employers that you also have a vested interest in the institution as well as your own profession. This enlarged perspective also is imperative for individuals who wish to become academic administrators.

Although the majority of job announcements are in *The Chronicle of Higher Education*, job seekers also should consult the journals and newsletters of professional associations, subscribe to the electronic bulletin board for health educators (HEDIR), seek advice from their major professors and check the job announcements often mailed to the departmental offices. Also, many of the national conferences host job banks and provide opportunities for potential employers to meet potential candidates. As you are searching for the job announcements, start to develop a list of desired qualities for your first job in higher education. Ask yourself "What size should the university be?" "Private or public?" "How many majors are in the health education program(s)?" "Do I want to work in a dual certified program, such as health and physical education?" "Teach community health education? or school health education? or a combination of the above?" Further consider, "Do I want to teach in a graduate program--masters or doctorate?" "Do I want to teach in an institution where teaching is the main expectation or where research is the main emphasis?" "Does the geographic location matter or will the size of the surrounding area make a difference?"

As you begin to picture the ideal job in the ideal program in the ideal institution, you may realize there are trade-offs and compromises unique to each situation. Perhaps the foremost thought at this stage should be to find a job where you can be fairly content and gain experience. Once you find a job announcement, you then can begin to match your ideal qualities in a position to the stated announcement. When you find a possible match or reasonable compromise between "ideal and real" you are ready to begin the official application.

Most job announcements will state the steps needed for individuals who wish to apply. Follow these steps to the letter! Often job announcements want applicants to send in a letter of interest or cover letter, a curriculum vita, *official* transcripts of undergraduate and graduate degrees and letters of recommendations and/or names of professional references. First, plan accordingly. Note the deadline for materials, does it state "received by" or "postmarked by"? Do not wait until the last minute. Assume the following: if the materials are not in, the file is not complete. Incomplete files are not reviewed.

Consider the following items as you complete your application packet. *The Cover Letter*: This often is the first document read by the search committee. This should be word processed and printed on quality paper. Avoid the harsh colors, use white or ivory color since these copy well. For most applications, the cover letter should be one page in length and never more than two pages. The purpose of the cover letter should be to introduce yourself and provide a description of how you match the job announcements. Since you will be including a curriculum vita, don't belabor the points. A strong cover letter is free of spelling errors, utilizes correct grammar and proper word usage and has a professional appearance. Include the name and address to whom you are writing and the date. If no specific name is listed in the announcement, address it to "Dear Search Committee Members."

Although there are many ways to start a letter, I would suggest the simplest. State where you read the advertisement, your interest in being considered for the position and how you believe you meet the stated qualifications. For the latter, consider what courses you are expected to teach, or other stated responsibilities. In the second paragraph, indicate your teaching experience at the college level and any research accomplishments. If you did teach, did you have sole responsibility for course development and grading or were you responsible for coordinating sections of a large introductory course or providing specialized instruction on specific

topics. Both are important and relevant. Don't try to add "fluff" or enhance your job responsibilities as a teaching assistant. Remember, most of the search committee members were also graduate students and teaching assistants. Many may be familiar with the doctoral program you are completing. Honesty and clarity are imperative. Also highlight major accomplishments thus far and indicate any specialized courses or training you have completed that will assist you in this position, such as curriculum development, grant writing, measurement, computer and multimedia expertise. Your final paragraph should conclude with home/work numbers where you can be reached. Also if the job requires a doctorate and you are still completing the Ph.D., give your most accurate (not idealistic) expected date of completion.

The Curriculum Vita: The curriculum vita, or cv, provides a chronological and detailed explanation of your career path thus far. Refer to Figure 1 for possible headings used in a curriculum vita. Search committees thoroughly review your curriculum vita. Specify the dates you were employed and major responsibilities for each job. Indicate which work experiences were paid, volunteer, or a part of an internship/practicum or class project. Identify which courses you have taught as well as your interest areas (hopefully these correlate to the stated job announcement). For presentations, indicate which were delivered at the national, state or community level as well as those for which you were you the sole presenter. For publications, indicate those that were peer reviewed and those that were not. Clearly identify your authorship role in manuscripts and publications, such as first author, second author, or fifth author. List all authors. If you have submitted a manuscript for possible publication, it is "under review." Manuscripts which have been accepted for publication are "in press." If you are working on research projects, state that in the interview rather than list on the cv. Also note that entry level positions typically don't expect the candidates to have a specified number of publications before the doctorate. A demonstration of your potential as a researcher and scholarly writer, however, is beneficial. Some class papers may be suitable for student authored papers in the *Eta Sigma Gamma*

Student Monographs or as teaching techniques published in *The Journal of Health Education*, or *Family Life Educator*. Additionally, third and fourth authorship with major professors often indicate a foundation in research skills and a willingness to pursue writing for publication.

Figure 1

Examples of Headings Used in a Curriculum Vita

I. Education (and Professional Certification)

II. Professional Experiences
- Current Position
- Courses Taught
- Teaching Experience (other)
- Related Work Experience
- Consultantships

III. Professional Interests

IV. University Service

V. Professional and Community Service

VI. Memberships
- Professional
- Honorary

VII. Awards/Honors

VIII. Presentations (peer-reviewed)
- National
- Regional/State
- Community
- Invited

IX. Peer Reviewed Publications
Journals
Monographs/Books
Abstracts
Book Reviews

X. Reports

XI. Grants

XII. Professional Development

The Letters of Recommendation: Please note that faculty writing reference letters for you will need ample preparation time and to be familiar with you. Acknowledge their time and efforts that will be needed and be sure to ask in a professional manner. That is, a hurried phone message or a cryptic electronic mail message is not the best option. A personal request with each writer, either in person or via the phone, is needed. At this time, provide a current copy of your cv as well as a copy of the job announcement for each writer. If possible, explain to your writer why this is a good job position for you. As an aside, a thank-you card for those who do write letters of recommendation also can brighten the days and demonstrate appreciation of their time and efforts. For ease of the search committee in determining complete files, you may wish to append a listing of names, positions, addresses, and phone numbers of those who are writing references. Also, if the job announcement requests three letters of reference, solicit three letters, not five. There is no need for overkill and it may be perceived as inattention to detail on your part. If you are worried that not all of your writers will be able to respond to your request, develop a mechanism to verify when recommendation letters are sent. Perhaps they would be willing to provide you with a copy of the letter. Also emergencies and last minute crises do arise, so have one or two alternate letter writers that may be contacted. Those writing letters do want to assist you in finding a job.

Note that these individuals will likely be writing letters of reference for a number of people. You also might want to discuss with the writers, prior to any job applications, if they feel comfortable recommending more than one individual for the same job. When possible, choose references from a variety of roles, those who are mentors and dissertation chairs, those who know of your teaching abilities, and those who know you in other work/volunteer experiences. It is helpful to discuss your career goals and desired qualities of a first job with these writers of recommendations to assist them in writing a customized letter when possible.

Teaching effectiveness is often difficult to convey in a cv. Therefore, it is helpful to have at least one person with firsthand knowledge of your teaching to provide a letter of recommendation. Additionally, graduate teaching seminars will appear on the official transcripts and student evaluations also may be integrated if shared with your reference writers.

Interviewing: Although each institution/department has its unique characteristics, there often are commonalities in the questions asked. See Figure 2 for a list of Frequently Asked Questions in interviews. To prepare for the interview, review the institution's undergraduate/graduate catalogs and any other materials they may send to you. If you have to prepare a presentation or teaching session, clearly identify your audience--faculty within the department, student majors, non-majors, and so on. Clearly follow the guidelines given (if any) and stay within your allotted time. Analyze the job description, why are you the perfect match? Also recognize that you may not be the "perfect match" but your education and background can assist you in meeting the challenges listed. Further, prepare a list of questions for you to ask the faculty if time warrants. What are the students like? What is the best feature about the program/institution that keeps the current faculty there? What are the main challenges at institution X? What do they value as a department? in new faculty members? Once the interview is done, reflect on what you learned. Can you picture yourself working there and becoming a member of the department? What are the initial strengths and weaknesses, what are the unan-

swered questions? Opportunities for advancement? Are there opportunities for collaborative teaching or research? What are the expectations for tenure and promotion? Who evaluates you within the department and outside the department? How are the evaluations conducted? Are there clearly defined criteria deemed necessary for tenure and promotion? How have other junior faculty members fared in the tenure and promotion process?

At this point in time, you have marketed yourself to the best of your ability, through your experiences, cv, and personal interview. While you are awaiting the department's decision, it is a professional courtesy to send a brief letter or card, thanking the department for the opportunity to meet with the faculty/students and acknowledging their hospitality and acts of kindness. Remember, although things may not work out at this point in time, you do want to leave a positive impression for these faculty also may be future colleagues at some time.

If you do not get the job, first realize that if there are a number of candidates for one position, the majority of candidates for any job will be disappointed. If you do get a job offer, you now must make a decision to accept or decline the offer.

Figure 2

Frequently Asked Interview Questions for an Assistant Professor Position

1. Why did you decide to apply for this job?

2. What unique characteristics do you bring to this job?

3. What courses listed in the catalog are you prepared to teach?

4. How can you apply your dissertation/dissertation process to this position?

5. What is your philosophy of teaching?

6. How do you distinguish between an undergraduate course and a graduate course?

7. How would you integrate the entry level competencies for health educators into a course on _____?

8. Name three role models and people you perceive as leaders in the health education profession.

9. What are your weaknesses in teaching?

10. How have you demonstrated leadership ability in your career thus far? (provide examples)

11. What is the ideal course you would like to teach and why?

12. What strengths do you have to offer other faculty as a collaborator in research projects?

13. Cite specific examples where you have demonstrated your commitment to diversity.

14. What committee work have you done? How would fellow members describe you?

15. What is your philosophy of graduate education?

16. Identify three main issues facing higher education today.

17. What one word would your fellow graduate students use to describe you?

18. If you were accepted for this job, how would you integrate applied research in undergraduate courses?

19. What advice would you give to other new faculty in maintaining competence in the areas of teaching, research, and service?

20. For each area, teaching, service and research, identify your main strength and weakness.

21. How would you define professionalism? How is that applied to health educators?

22. How would you describe your computer skills?

23. What would you do if you caught a student handing in a plagiarized paper?

24. What are the three most important characteristics of an advisor/director of a thesis?

25. What is your most important feature of a job?

26. In your opinion, what is the most important outcome for our graduates?

27. How do you teach critical thinking skills in a health education course?

28. What methods, other then tests/exams, are your preferred methods of assessment and why?

29. What are the characteristics of a "poor teacher"?

30. After your dissertation is published, what is your next focus in the research arena?

Negotiating a Contract: When the job offer emerges, give yourself time to think it through. Most search committees expect and want you to think about the offer. Both parties are taking a risk and both want the decision to be the right one. Of course, salary and benefits often drive the discussion at this point. Realize that some institutions are bound by collective bargaining agreements and truly do not have much room for flexibility in terms of salary. Consider your level of experience and qualifications, remember your first job is entry-level. Is the salary for a 12 month appointment or nine month appointment? What amount of teaching is required during that appointment? Is summer employment optional or required? What is the cost of living in that area? Does your contract place any restrictions on other part time employment or consulting activities? What is the state income tax? How often are cost of living increases granted? Does merit pay exist and under what criteria? Do you move up in the salary scale after a satisfactory performance review?

Although salary scales may be somewhat inflexible, other components of the position may offset a lower salary. For example, will you have a computer, printer and/or multimedia access? Is there a budget for continuing education and conference attendance? Is your travel budget dependent on presenting papers? Can you have a lighter teaching schedule the first year in order to start your research agenda, for example, publish your dissertation? What types of support services are available for writing for publications and presenting at national meetings? Are moving expenses paid or is a mileage reimbursement given if you need to make another trip to find housing? Will the institution offer assistance in finding a job for your spouse/domestic partner?

Predictably, each institution will offer a different package of perks and drawbacks. Most institutions have limits on the packages they can offer, especially for new faculty without established records of teaching effectiveness, scholarly growth and service. Although the tangible and quantifiable influences do play a deciding factor, do not ignore those intangible and qualitative influences.

Do you perceive this to be a "good fit" for your professional development goals?

What About Leaving "All But Dissertation"?

In some job announcements you may see the phrase "ABD" considered. This means that if candidates have completed all dissertation requirements except the dissertation, they may be considered for a position. Simply stated, don't do it! If you accept a new job, you will be focusing on new courses/course preparations, committees, perhaps advising and the general process of acclimating to a new job and new location. Where are you going to find time to finish the dissertation as well as successfully manage the new demands? It is a rare institution that will provide release time (and lessen your workload) for completion of degree requirements. Other support services, statistical assistance and software and phone/photocopying expenses for your dissertation may not be adequately covered by your new department's operating budget.

The mere thought of continual "phone tag" with your committee members also should give cause to reconsider the ABD option. Often the completion of the dissertation also will be written into your contract. Consequently, failure to complete the dissertation may terminate your employment. More significantly, your tenure and promotion journey typically starts your first semester of employment. While other new colleagues (your tenure and promotion cohort) are *publishing* their dissertations, you already are lagging behind by still *working* on your dissertation. Note that leaving ABD is distinctly different from leaving without receipt of diploma. In the latter situation, your dissertation is completed but you have missed the Graduate School deadlines so the actual date of graduation is delayed. This situation can be addressed by having your dissertation chair and/or Graduate Dean write a letter verifying that you have completed all degree requirements.

Balancing and Juggling: The Pre-Tenure Years

Once you have accepted a position in higher education, insist on clear job expectations that will guide you in making the best decisions as you seek tenure and promotion. What will your main responsibilities be in the areas of teaching, scholarship, and service and how will your progress be assessed in each of those areas? Also realize that you must think about tenure and promotion your first year, it cannot wait until the third and fourth year. Perhaps the most important skill to master will be time management and setting priorities for yourself, which includes a life away from the office, too. Become a solid teacher and competent advisor to students. Don't be afraid to seek out assistance or new teaching strategies from other faculty. Demonstrate your ability to function as a team player and a departmental member and not just an individual faculty member. The ability to be a team player while also selectively saying "yes" and "no" to a multitude of campus activities will be a lifelong process with shifting priorities. Find a mentor at your new institution, preferably from outside your home department to assist you in the acclimation process and learning about your new campus culture. Above all, realize there will be times where you will feel overwhelmed. This is the time to call those friends from graduate school to commiserate and share past stories of challenging times and to identify goals for the future. Higher education is experiencing a time of increased accountability, public scrutiny and limited resources. Intermingled with the challenges will be a host of rewards and positive strokes, from your students to new campus colleagues and other professional acquaintances. Careful planning, wise choices, and the motivation to go the extra mile in graduate school can enhance your success as a junior faculty member. Welcome to the Academy!

CHAPTER 10

PREPARING HEALTH EDUCATORS FOR ACADEMIC MEDICINE: THE HEALTH CARE REFORM OPPORTUNITY

James J. Neutens, Ph.D.

> *The physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make for physical and moral well-being.* (Flexner, 1910).

While preventing disease, disability, and death have been tenets of health education for a longtime, they have largely remained as illusive targets in medicine. As evidenced by the 1910 Flexner report quoted above, it is not that medicine has failed to recognize the importance of this doctrine, but rather has possessed an inability to practice it. Medical education, in particular the academic medical school, appears to be a major contributor to the status quo of medical philosophy and orientation. According to Bloom (1988), "Despite a half century of radical changes in medical practice, the teaching/learning experience of medical students has remained remarkably similar" (p. 294). Although curricular changes in medical education have been abundant, history shows them to be reforms without change. Throughout the years, resistance to change has been supported by the American public who embraced our health care system. Today, however, the unprecedented push for health care reform has placed public health,

health promotion, and disease prevention at the political forefront. Just as the powerful forces demand changes in health care delivery, so, too, do they call for reformation in medical education. The thesis herein is that while graduate health educators can be instrumental in all three areas of medical education--education programs, research efforts, and patient care--their greatest impact should be in education and research.

Health Care Reform: The Impetus For Change

Health care transformation is taking place at federal, state, and local levels (O'Neil and Seifer, 1995). The federal level is seeking universal access, an emphasis on prevention and health promotion, and individual choice. The states are looking for any avenue that will relieve them of the tremendous financial burdens of Medicaid while simultaneously increasing care for all citizens. Many states have replaced Medicaid with MCOs (Managed Care Organizations) that have become the new champion of health care--by the year 2000 almost two-thirds of the population is likely to procure their health care through an MCO (Bulger, 1995). MCOs often take medical decisions away from physicians by dictating or giving approval for selected medical procedures and medications. At the local level, hospitals are "buying" physicians--making them hospital employees rather than individual entrepreneurs. Primary care doctors are being sought by everyone while specialists are on the brink of being too many in number. This need for primary care physicians--generally considered to be family medicine, internal medicine, and pediatrics--is a definite shift from the past. The specialty of obstetrics and gynecology has been listed as a primary care area by the Accreditation Council of Graduate Medical Education (for the United States) but is not widely recognized as such by many MCOs.

These changes have had unique effects on our nation's academic medical centers, not the least of which is a reduction in the flow of dollars for education, service, and research. As teaching hospitals negotiate contracts with large third party payers and

managed care organizations, they find their clinical income significantly reduced. This, in turn, reduces the dollar amount available to subsidize medical education. In short, unlike the past, this time change will come with reform.

Challenges to Academic Medicine and The Graduate Health Educator

Except in a few instances, the American medical school comprises two components. The first is two years of basic science followed by two years of clinical medicine. This four year curriculum leads to the M.D. degree which is followed by at least one year of internship in a hospital. The usual pathway is three years of residency after medical school (at least in the case of the primary care programs, although obstetrics and gynecology is four years in length).

The philosophy of most medical schools and residencies is reductionist in nature. That is, biomedical knowledge is honored as the most important aspect of medical education and, as such, requires teaching by specialists to make our young physicians applied biological scientists (Bloom, 1988). The competing and oftentimes subservient philosophy is social ecology that sees patient and community needs as the basis for medical education. This "humane" approach gives serious concern to community issues, preventive, and behavioral medicine. Unlike health educators, physician models and students have not been motivated or compensated to perform or train in the humanistic areas provided by preventive medicine, public health, or even family medicine (Council on Graduate Medical Education, 1992; Committee for the Study of the Future of Public Health, 1988; Gottlieg and Holman, 1992; Gellert, et al, 1991).

The winds of change brought about by health care reform are sympathetic to social ecology which is very much akin to health education ideology. Table 1 summarizes the issues or forces caught up in these winds. The left side of the table illustrates the current system in healthcare and academic medicine; the middle

column shows how these issues are likely to be by the year 2005 (Bugler, 1995; Greenlick, 1995; O'Neil and Seifer, 1995; Shugars, et al, 1991). The column on the right outlines the preparation needs of the graduate health educator to function as an educator/administrator within an academic department at a medical teaching center. All eleven of these major issues fall into the purview of the graduate health educator.

Table 1

Forces on Academic Medicine and Graduate Health Educator Preparation

Current System Health Care Academics	Emerging System Health Care and Academics	Preparation Needs Graduate Health Education
Reductionist Model Curriculum	Social Ecology Model Curriculum	Basic Health Education Philosophy; Curriculum Assessment, Planning Implementation, Evaluation
Specialized Care and Specialists Doing the Teaching	Primary Care Orientation and Generalists Doing the Teaching	Medical School and Residency Pathways; Community Needs; Public Policy; Curriculum Design; Human Resource Management Skills; Teaching Skills; Innovative Strategies for Teaching, Evaluation
Individual Patient Based	Population Based	Epidemiology, Statistics, Evidence-Based Medicine

Table 1 (cont.)

Current System Health Care Academics	Emerging System Health Care and Academics	Preparation Needs Graduate Health Education
Biomedical Research	Health Services Research	Qualitative and Quantitative Research Strategies; Applied Research; Resource Skills
Illness Orientation	Wellness Orientation	Health Education Philosophy
Cure	Prevention, Health Promotion, Behavior Change (Public Health Orientation)	Health Promotion, Social and Behavioral Sciences, Social Marketing Knowledge/ Skills
Physical Mode of Thinking	Biopsychosocial Approach	Assess Comprehensive Needs of Individual and Community
Technology Orientation	Humane Organization	Assess Community Needs; Ethics
Unaware of Costs	Cost Awareness	Teach Resource Utilization; Ethics; Coordinate Services
Solo or Small Practice	Teams, Large Organizations	Social Marketing
Competition among Physicians in Practice, Academic Departments	Cooperation Across All Health Care Professions	Communicate Needs, Concerns, Resources; Managing and Supervising Skills; Human Resource Management Skills

The most blatant shift in medical schools is the increase in the education of generalists and the downsizing of specialists. Health care reform has called for 50 percent of medical students to be on a generalist tract. Also, it is requiring generalists "...to acquire new or enhanced skills in health promotion and disease prevention, epidemiology and biostatistics, the social and behavioral sciences, economics and management, medical informatics, and the practice of evidence-based medicine" (Eggert & Parkinson, 1994, p. 689). This drastic curriculum change is ripe for the graduate health educator. Present training prepares graduate health educators to teach in most, if not all, these areas.

Health services research is a must as physicians shift to population based practices. Medical students and the emerging health care system alike will require new information--population and community needs, efficacy of care, cost care containment, patient outcomes, necessary technology, collaborative practices, and health education. Applied research has been the mainstay of health education since it's inception. Qualified graduate health education researchers can play a significant role in medical school and residency settings.

The medical school culture requires drastic change if survival is to occur. Prevention and health promotion are likely to be cornerstones for wellness orientation, biopsychosocial thinking, cost awareness, humaneness, and cooperation. This is no easy feat and the presence of graduate health educators who comprehend and empathize with present and emerging philosophies can be of great benefit to the medical education of future physicians. The Pew Commission (O'Neill, 1993) has identified physician competencies for the next century. As seen in Table 2, they are in concert with the emerging trends, with health education convictions, and with the training of graduate health educators, especially at the doctoral level.

Table 2

Practice Prevention
Get patients and families involved in decision-making
Encourage healthy lifestyles
Offer counseling on ethical issues
Provide appropriate care in a cost-effective manner
Make the community's health a priority
Join in coordinated care for patients and the community
Be involved in continuing medical education
Be a wise user of technology
Be able to manage large amounts of information

The faculty and administration in academic medical centers will need to demonstrate a spirit of cooperation through commitment to multi-professional team approaches and to teaching. The era of competition must give way to faculty collegiality across all health professions. Given a wide knowledge base, graduate health educators can initiate and coordinate multidisciplinary efforts. Graduate health educators versed in pedagogical methods can bring a whole new meaning to role modeling, innovation, student-centered teaching, and evaluation.

Health educator administrative skills, managing and supervising, in particular, are very applicable to long range and strategic educational planning, curricular change, program implementation, allocation of teaching resources and personnel, and critical analysis of future edu ional needs. These skills can be significant at departmental and college-wide levels.

As medicine progresses into a new era and practitioner competencies change, the place for values and moral behavior will increase. The graduate health educator should be able to apply ethical principles to health education and to medicine. As a minimum, the health educator should be able to interface with the medical ethicist in the hospital or the medical ethics department in the medical school.

Entry Points: Some Pragmatic Suggestions

Practical avenues for entry into academic medicine for faculty who prepare graduate health educators are:

1. Gain knowledge of medical education at both the undergraduate and graduate levels of training. This knowledge can be general to include: number of years in medical school, number of years in residency programs, the nature of the curricula, and the core knowledge and skills in the basic preventive curriculum. The four subject areas of the medical undergraduate preventive curriculum are preventive services, quantitative methods, health services organization, and community dimensions of practice (Association of Teachers of Preventive Medicine [ATPM], 1994). At the graduate level, preventionists are trained in public health and clinical medicine with focus on one of three areas: general preventive medicine/public health (GPM/PH), occupational medicine (OM), or aerospace medicine (AM). All three programs build upon the undergraduate core of ATPM and share a common knowledge and competency base (American College of Preventive Medicine, 1991). In short, have a knowledge base that will allow you to (a) determine how your program could interface with existing programs, and (b) talk intelligently with medical faculty about infusing graduate health educators into the system.

2. Check with your nearest medical school and/or community hospital that provides education to residents. Determine the administrative structure to seek *"your"* best point of entry. For example, if you have expertise in sexuality education, you may want to visit with the residency program director in obstetrics and gynecology or family medicine to see if there is something you could do for them. Another way is to offer your educational services to teach research methods or consult on resident (and perhaps faculty) research projects. This is a "side door" approach but would give you contact. If there is a Director of Education or an Associate Dean who oversees educational opportunities, that may be an entry point. If your program has an MPH degree, that could provide direct access. The key here is to risk entering at some

point but doing so with a knowledge base that will let you "sell" what they "need" by explaining how your programs can dovetail. Keep in mind that public health topics are already in the door of many programs--especially primary care programs.

3. Expect skepticism from some people in academic medicine. However, keep in mind they are undergoing many changes now and, for many, denial is still a factor. The key is to keep trying--it may be a matter of a different entry point.

4. Immediate things that you may be able to offer via graduate students are: (a) linkage to health education programs in K-12 settings that could involve medical students; (b) some degree of direct teaching or facilitation for some topics; (c) internships in which a student could look at clinic organization, teaching approaches, time allotted for teaching, teaching pedagogy, and so on; and (d) research needed by a department that could be completed as a dissertation and of course be of benefit to the student. Reviewing Tables 1 and 2 in light of your program should offer even more ideas.

5. In preparing graduate health educators, faculty should devote some time to teaching about academic medicine. In many instances this can be an expanded part of an existing course or become part of a graduate level seminar. Guest speakers from medical schools and/or residency training programs can be invited to address a myriad of issues. This has the dual role of establishing contact.

In summary, the emerging system of academic medicine is not only amenable to graduate health educators, it can provide opportunities in an unparalleled fashion. However, these opportunities will only be grasped by those who are prepared and willing to move beyond the boundaries of traditional health education settings--including patient education in a medical setting.

References

American College of Preventive Medicine. (1991). *Directory of preventive medicine residency programs in the United States and Canada*. (6th ed.). Washington, DC: Author.

American Medical Association. (1993). *Graduate medical education directory*. Chicago: Author. [Note: this publication contains general requirements for all residency programs and is updated yearly].

Association of Teachers of Preventive Medicine. (1994). *An inventory of knowledge and skills related to disease prevention and health promotion*. Washington, DC: Author.

Bloom, S.W. (1988, December). Structure and ideology in medical education: an analysis of resistance to change. *Journal of Health and Social Behavior, 29*:294-306.

Bugler, R.J. (1995, January). Generalism and the need for health professional educational reform. *Academic Medicine, 70*(No. 1 Supplement):S31-S34.

Committee for the Study of the Future of Public Health, Institute of Medicine. (1988). *The future of public health*. Washington, DC: National Academy Press.

Committee on Graduate Medical Education. (third report). (1992). *Improving access to health care through physician workforce reform: Directions for the 21st century*. Rockville, MD: US Department of Health and Human Services.

Council on Graduate Medical Education. *Improving Access to Health Care Through Physican Workforce Reform: Directions for the 21st Century*. Rockville, MD: US Department of Health and Human Services,

Eggert, R.W. and Parkinson, M.D. (1994, September 7). Preventive medicine and health system reform: Improving physician education, training, and practice. *Journal of the American Medical Association, 272*(9), 688-693.

Flexnor, A. (1960) *The Flexnor Report on Medical Education in the United States and Canada.* A Report to the Carnegie Foundation for the Advancement of Teaching. Bulletin No. 4, Boston: MA, Updyke, 1910 [reprinted Besthesda, Maryland: Science and Health Publications].

Gellert, G.A., Kooiker, H., and Neumann, A.K. (1991). Regaining the preventive medicine edge: Training for 2000 and beyond. *American Journal of Preventive Medicine, 7*:183-187.

Gottlieb, L.K. and Holman, H.R. (1992). What's preventing more prevention? Barriers to development at academic medical centers. *Journal of General Internal Medicine*, 7:630-635.

Greenlick, M.R. (1995, March). Educating physicians for the twenty-first century. *Academic Medicine*, *70*(3): 179-185.

O'Neill, EH., (1993). *Health professions education for the future: Schools in service to the nation.* Report of the Pew Health Professions Commission. San Francisco:CA, Pew Health Profession Commission.

O'Neil, E.H. and Seifer, S.D. (1995, January). Health care reform and medical education: Forces toward generalism. *Academic Medicine, 70(*No.1 Supplement):S37-S43.

Shugars, D.A., O'Neil, E.H., and Bader, J.D. (Eds.) (1991). *Healthy America: Practitioners for 2005: An agenda for action for U.S. Health Professional Schools.* San Francisco: Pew Health Professions Commission.

CHAPTER 11

BEING A T.A.: BALANCING BEING A "PRO" AND A STUDENT

Onie R. Grosshans, H.S.D.
Jodi-Brookins Fisher

(Normal type is administrator response, italic type is teaching assistant response.)

Introduction

The use of graduate students to assist faculty in any number of ways has been a vital component of many departments for most of this century. Each university/college may define teaching assistants (t.a.), research assistants (r.a.), graduate assistants, and graduate fellows differently. How clearly t.a. roles are defined is critical to the expectations placed on them by their departments. Use of teaching assistants may vary among the schools and colleges on one campus. For example, five classes may be a full-time teaching load for a t.a. in the Language Department, while two classes make a full-time teaching assignment for a t.a. in the Department of Health Education. My comments will only focus on t.a.s--meaning those individuals who are assigned teaching responsibilities that involve direct student contact as instructors of record. My university defines an r.a. as a graduate student assigned directly to externally funded research projects, and a g.a. as one who assists faculty with other research or with teaching a class, such as administering and grading assignments/tests, meeting with students, or computing final grades.

Graduate students should be a t.a. if they want to pursue a teaching career at the college/university level. This invaluable

opportunity will help one develop or further perfect teaching skills, while adding some important experience to one's resume. It also gives one an advantage (not favoritism) in the department due to continual exposure to faculty and staff. Of course the obvious benefit is that the assistantship usually comes with a stipend and/or tuition waiver. A professor once told me you should never have to pay for school at the graduate level. Although this won't be the case for everyone, if one has a high grade point average, good references, and the right personality for the job, this statement should hold true.

Dual Role Conflict

The t.a. is an integral part of both the undergraduate and graduate programs of a department. How well the t.a. conducts an undergraduate class directly impacts the reputation of the department. The t.a.'s own intellectual capability and excitement about learning influences the quality of his/her participation in the graduate program. So, it is understandable when being an instructor and being a graduate student may result in role conflicts.

Obviously, department policy will clarify objective issues such as length of contractual agreement, process for reappointment as well as dismissal, requirements of a full teaching load, number of office hours per week, if attendance at faculty meetings is mandatory, voluntary, or not required at all, scheduling of regular instructor evaluations, and the amount and type of support services available.

It is the subjective areas where dilemmas occur. What classes are assigned to the t.a.s? Who receives preference for teaching times and specific courses? Is class size taken into account when making class assignments? When does department necessity give way to needs of a graduate student, and vice versa? An emergency situation may be caused by a variety of events: a last minute resignation of either a t.a. or full-time faculty member, a serious accident, a complicated pregnancy, a lengthy illness, or even a change of time of a vital graduate class by another depart-

ment for one of your t.a.s. Assuming the best case scenario would be a combination of faculty and t.a.s rearranging their schedules, the question is one of priority: Does the need of the department take priority over the individual need of the t.a.? Regardless of the reason, the class has to be covered.

As to what classes are assigned--inexperienced t.a.s start with our basic personal health class. The first quarter he/she audits one section taught by an experienced instructor (either faculty or t.a.), teaches only one class, and then meets on a regular basis with a faculty mentor. When preference of class or class time is possible, t.a. seniority is the rule. Class size is also considered when making class assignments, either by being accommodated for during that same quarter, or being 'made up' in a future quarter. It is a toss-up as to what is more fair: two large classes but one preparation, or two smaller, but different classes and two preparations. Fairness is attempted, but experience with the subject matter prevails. Again, depending upon the prior experience of the t.a., the department attempts to vary the teaching assignments during the second (and third) year. When experienced teachers become our t.a.s, I do not hesitate to assign them higher numbered classes, nor do I hesitate when a new t.a. shows competence with each progressing quarter.

The preferred approach for dealing with unexpected change(s) in faculty/t.a. assignments is to meet with the concerned individuals, present the problem, discuss possible solutions, and, hopefully, agree upon a resolution. There have been times when the t.a.s have simply rearranged classes among themselves to cover the 'orphaned' class. At other times, faculty have assumed an increased teaching load, or faculty/t.a. have team taught the class. There is no set solution, but rather a group of concerned professionals have made sure a class is not cancelled.

I feel in most regards, t.a.s are seen as extended faculty. My department chairperson likes t.a.s to attend faculty meetings which was not the case in other departments where I was a teaching assistant. This is a bonus because it gives one insight into the dynamics of a faculty, and how administrative and financial

decisions are negotiated. You also learn the politics of a work place. This is great foresight into future work place staff meetings and gives one an idea of what to expect. You also get to be involved in much of the decision making (such as curriculum changes) that affect you and other graduate students. Sometimes the last business of the faculty meeting involves discussion of graduate student progress. We are always excused at that point, which is appropriate since the discussion involves our peers. Most t.a.s do not serve on any faculty committees. The only departmental affiliation we're involved in is Eta Sigma Gamma, which is on a voluntary basis.

Balancing workload and course work is the key to a successful graduate experience. It is also perhaps the most difficult. Balance is necessary to do a good job at both teaching and being a student. This balance is individualistic, some can handle more than others. One would say course work is why you are there, but if you want to continue to teach at the university level, this is not necessarily the case. Both may be equally important, and both can get in the way of the other. Organization is a must!

In our department, a t.a. has total responsibility for a class. This is not a university-wide policy, so there are large discrepancies between pay and workload. Teaching two classes per quarter is a lot for the money, depending on the class size and course content. T.a.s in our department are assigned a variety of classes, depending on experience, preference and need. Teaching times are usually not selected, although accommodations can be made to fit the t.a.s own course work. The size of classes vary from 10 to 125 students. Three office hours per week must be kept. The department secretary is available for administrative purposes, and copying can be done with a departmental signature.

Fairness between t.a.s can be a big issue. One t.a. may be assigned two classes of 100 students each, while another t.a. is assigned two courses each with 30 students. Additionally, some t.a.'s teach higher division courses while some only teach introductory level classes. These differences are most obvious during the busy times of the quarter! The grass is always greener... However,

the department tries to meet each student's needs (as well as its own) in a variety of ways, so this may be necessary, or just coincidental.

It is also nice when former t.a.s are around to mentor new academic student appointees. This is not usually the case due to relocation and other commitments, but it does help acclimate t.a.s to their new role as a teaching assistant.

Responsibilities of a T.A. - and the Department

As mentioned above, the t.a. is both a graduate student and a faculty member. As the instructor of record, the t.a. represents the department and his/her students may be getting their first (and perhaps only) impression of health education from this individual. There is a fine line of responsibility to ensure that enrolled students have a quality educational experience while, at the same time, providing the new t.a. with a positive teaching experience.

The prior teaching experience of the t.a. determines how much time is devoted to helping the graduate student prepare a course outline, develop lesson plans, discuss teaching techniques, select evaluation measures, create assignments, and so on. An inexperienced t.a. will have to learn the skills and techniques of teaching as well as how to interact in a professional manner with students. The necessity of a mentor working closely with this type of t.a. is critical. Inadequate teaching skills reflect poorly on the department. Inappropriate and/or unprofessional behavior with undergraduate students may bring legal and/or university condemnation. The department wants to help a t.a. grow professionally, but how much leeway can be given, how much supervision is needed, how much assistance can be extended while still being cognizant of the department's responsibility of providing a quality experience for the undergraduate students is best addressed on an individual basis.

How much prior teaching experience your t.a. has depends upon your method of selecting t.a.s. My department has a separate application process for this area. Applicants identify past teaching

experiences (formal teaching situations are preferred over informal, infrequent encounters), and content areas they are most comfortable/least comfortable teaching. Viable applicants are then interviewed, either by phone or in person, to discuss in more depth the extent of their teaching experiences and to assess their love/enthusiasm about teaching.

Once the t.a. is accepted, one of several faculty serve as a mentor. The more inexperienced the t.a., the more supervision is provided. Also, each quarter a course/instructor evaluation is conducted of all faculty/t.a.s. Two copies are made of the summary document, one for the instructor and the second to the department chair. Each t.a. then meets with the department chair to review the summary, discussing strengths, weaknesses, and recommendations for improvement.

Another dilemma occurs when a t.a. is so competent and capable that the chair as well as other faculty relate to that individual more as a colleague than as a graduate student. Although it is a compliment to the abilities of the t.a., it also may pose problems of unintentional overwork. For example, if a t.a. is particularly competent in teaching, it is tempting to have that person serve on a committee that oversees the integration of undergraduate class content, or work with a new t.a., or attend workshops or other meetings to update the department. To agree to any or all of these requests means the t.a. must make time to meet, discuss, inform. Being truly interested in contributing, however, the t.a. will make the sacrifice. As an administrator, I want the best possible input for maintaining a quality program, but I also don't want to add a burden to an already tightly scheduled t.a. It is as much the responsibility of the department chair to protect the competent t.a. from benevolent abuse, as it is to work with the inexperienced t.a. to develop expertise.

There is a real struggle in being a t.a. You are representing the department and want to do the best job you can while still maintaining your own course work and grades. You also want to give t.a.s a good reputation, so you do your best. This takes a lot of preparation. Perhaps auditing a class from an experienced

instructor is the first step to seeing how its done. It also requires a variety of teaching methods and being familiar with the text you assign your students. A t.a. must develop his/her own course outlines, lesson plans, and exams. You may get samples from others in the department, but basically this is another responsibility. It is also important that one is not so bogged down that they can't keep abreast of new information. Updating yourself at regional, state and national conferences is very beneficial if your financial situation allows it (or your department provides financial assistance), and by reading professional journals.

It is also important that one continuously remember you are there for the student and to help the students learn. Give them their money's worth! They deserve to have their classes taught in a professional manner. Professionalism can be difficult when many of your students are close to your own age. One must always practice the highest degree of professionalism which reflects on the reputation of the department.

Besides balance, being organized is another indicator of a successful t.a. and graduate student. There is no room in your schedule for procrastination, so planning proves to be your best method of staying on top of your own course work and the classes that you teach. People who are prepared do well--those that aren't usually compromised by their teaching and academic success.

Conclusion

The advantages of being a t.a. are overwhelmingly positive--IF the experience has been a good one for both parties. As department chair, I can later write (or speak) specifically about the qualities of the graduate student's academic achievement, sense of commitment, responsibility, typical work habits, and professional conduct in and out of the classroom.

Being a t.a. is a very rewarding experience if you put the best of yourself into it. Especially rewarding are conversations with faculty who provide valuable insight into a variety of class-

room issues. Getting quarterly course/instructor evaluations and feedback from students is a good indicator of a job well done. This helps one build a reputation as a competent t.a. and helps with future employability.

CHAPTER 12

TURNING COURSE ASSIGNMENTS AND PROJECTS INTO PROFESSIONAL CONTRIBUTIONS

Robert J. Bensley, Ph.D.

Graduate programs are designed to provide students with research skills and knowledge to plan, implement, evaluate, and manage health education programs. As exhibited in the professional literature and at conferences/workshops, many recent graduates of masters and doctoral programs have made significant contributions to the health education profession. Usually this is a result of reporting the findings of their research. The process of putting into practice these skills, however, need not wait until completion of the graduate program. Many graduate assignments and projects focus application of new skills and innovative approaches to existing problems or issues. Unfortunately, many of these creative ideas are put aside, never to be pursued at a professional level.

The professional benefits associated with graduate education assignments can be numerous. Completed projects may contain a multitude of answers to perplexing problems that have traditionally been barriers to successful health education and health promotion efforts. A number of "seeds" may exist that, if brought to the attention of other professionals, may germinate to new, innovative approaches. Transforming course assignments and projects into professional contributions both enhances the profession and is a means for graduate students to: 1) become familiar with professional expectations, 2) become known to potential employers, and

3) establish credibility. It is imperative that creative ideas and solutions that emerge during graduate study are neither lost nor dismissed due to the lack of belief in their value to the profession.

Many opportunities exist for graduate student professional contribution. The more obvious include journal publications, newsletter articles, and conference presentations. Many professional journals and newsletters, at the state and national levels, focus on issues associated with health education and health behaviors. Similarly, many professional organizations host a variety of national, regional, or state conferences and workshops that focus on health issues. Less obvious professional contributions include chapters in professional texts and entrepreneurial activities such as marketing educational materials and services.

Selecting Topics that Sell

An advantage of graduate education is that subject areas from which assignments and projects are completed are usually based upon the student's interest or past experiences. This allows for tremendous flexibility in selecting topics that have the potential to become professional contributions. In addition, it permits students to build a base for future professional activity by expanding their knowledge and experience in specific areas of interest.

Assignments and projects that focus on state-of-the-art issues in health education are of interest to the profession due to a lack of or limited information. Professional organizations and journals are more likely to be interested in reporting results of research or current health education issues rather than information that has been previously published or presented at conferences. For instance, a greater need currently exists for information pertaining to issues such as the role of health education in health care reform, health education and the internet, violence prevention, resilience building, political activism, and evaluation of community coalition efforts than issues that saturate the professional literature (e.g., association between weight management and fitness, HIV/AIDS education, and employee wellness behavior change programs).

Similarly, the profession continually needs new innovative approaches for dealing with controversial issues such as sexuality and holistic health practices.

Focusing on future concerns also may provide an avenue for professional contributions. Many have predicted that health problems in the 21st century will differ dramatically from current issues. It has been suggested that issues such as "technostress," mind/body medicine, computer-assisted delivery of health education, fee-for-service health education, home health education, health hazards associated with environmental concerns, new strands of deadly viruses, and school-based family health education services will be major future concerns of the profession (Bensley, 1990; Breckon, Harvey, & Lancaster, 1994; Butler, 1994).

The number of subject areas that assignments and projects are coordinated around may impact the likelihood of professional contributions. One approach is to use different topical areas for each assignment. The advantage of this approach is that the student becomes versatile in a number of health education topics. The potential for professional contribution may be greatly enhanced, however, when assignments and projects are coordinated around a common subject area or theme. Use of a common theme allows for the ability to utilize data and information obtained during one project as a base or supplement to one or more other project(s). Coordinating assignments and projects results in an advanced understanding and knowledge of a specific subject area or process and assists the student in establishing a solid base for future professional endeavors.

Finally, it should be noted that graduate faculty have varied expertise and experiences associated with health education issues. In particular, they can assist in formulating ideas and selecting topics that are likely to be of interest to the profession.

Turning Course Assignments into Professional Presentations

Perhaps the easiest way to contribute professionally is by

presenting a paper at a conference or professional meeting. Assignments or projects that focus on the effectiveness of original health education approaches, innovative ideas, creative application of theory, or testing of new theories/models appeal to health educators. Professionals continue to search for new approaches that will assist in meeting the health needs of specific populations.

The first step in developing a presentation involves identifying the professional association and presentation method most appropriate for the course assignment or project. Five avenues exist for professional presentations: 1) national, regional, or state conference presentations; 2) national, regional, or state conference poster presentations; 3) state or local workshops; 4) community presentations; and 5) presentation panels and round table discussions. Associations that may have interest in the student project as a conference presentation include national health education/promotion associations (e.g., Eta Sigma Gamma, Association for the Advancement of Health Education, Society for Public Health Education [SOPHE], American School Health Association, Association for Worksite Health Promotion, American Public Health Association, American Alliance for Health, Physical Education, Recreation, and Dance [AAHPERD]), state or regional chapters of national associations (e.g., regional chapters of SOPHE; state associations of health, physical education, recreation and dance; district AAHPERD, state public health associations), and local groups (e.g., Y.M.C.A., churches, public health departments, corporate worksites, schools, etc.).

Papers selected for conference presentations are frequently based on projects that are closely related to the theme of the conference. They are typically based on informational concepts, teaching or implementation strategies, a reporting of research findings, or the application of theory into practice. Papers submitted for acceptance as a presentation can be from either a single presenter or a group of individuals. As most graduate work is completed under the close guidance of a mentor, student and mentor co-submission of a presentation may enhance the acceptance of the proposal.

Poster presentations are effective methods of presenting research findings. Most national conferences include at least one poster session consisting of many different research topics. These sessions are excellent for presenting descriptive studies and results from research projects, especially thesis and dissertation findings. Graduate students have been traditionally encouraged to submit research projects for consideration as poster sessions.

Workshops can be either invited presentations by an organization associated with the health education profession or sessions initiated by the presenter. For instance, an individual completes a graduate project that incorporates resilience building techniques into smoking cessation. As a result, 1) they may be requested by a local health agency to conduct an in-service training for public health educators, 2) the student's graduate mentor may refer the student to an association that would be interested in conducting a workshop based on the topic, or 3) the student may solicit agencies that would be interested in sponsoring a workshop on resilience building and smoking cessation.

Presenting at the local level is one of the easiest ways to gain professional experience. Many organizations such as churches, community volunteer agencies, worksites, schools, and community centers work with populations interested in health. Graduate students usually have expertise in issues that are consistently in the public focus (e.g., state-of-the-art HIV/AIDS information, violence, adolescent values).

Many conferences and workshops incorporate panel presentations or round table discussions. Panels consist of experts in certain topics or issues associated with the discussion. A round table discussion typically consists of a speaker informally sharing information to a group that is literally gathered around a table. Round table discussions usually focus on innovative program methods and strategies. A student who has conducted a number of studies and completed a number of assignments and projects associated with a specific topic or issue in health education can be a valuable asset to these forms of discussion.

Many graduate students have contributed to the profession by publishing informational and research papers previously presented at professional meetings or by submitting manuscripts to professional journals. Advantages of submitting a presented paper for publication include reaching a larger audience and transforming a graduate project into more than one professional contribution.

A number of professional journals exist that are appropriate for the scope of graduate assignments and projects. Sechrist and Governali (1990) identified over 400 national periodicals that are relevant to health education content, theory, or process. In addition, many national, state, and community organizations regularly publish periodicals. For instance, the *Journal of Health Education* is a publication of the Association for the Advancement of Health Education, the *Journal of School Health* is a publication of the American School Health Association, and *The Health Educator* is the official journal of Eta Sigma Gamma National Health Education Honorary. State and local organizations are less likely to produce a journal but may have a monthly or quarterly newsletter or some other type of publication.

Students interested in writing for publication should become familiar with the writing style associated with the publication (e.g., A.P.A. style) and incorporate the style into writing assignments and projects. They also should view all writing assignments as potential publications. Developing a writing style compatible with the requirements of specific journals may be accomplished by becoming familiar with previously published articles.

The types of assignments and projects with greatest likelihood of publication include: 1) research based projects, 2) literature reviews, 3) conceptual or philosophical papers, and 4) teaching methods or implementation strategies. For instance, an innovative teaching method that was completed as an assignment in a methods and strategies course may be valuable to health educators. Many periodicals such as the *Journal of Health Education*, the

Journal of School Health, *The Health Educator*, and *Family Life Education* publish teaching methods as regular journal features.

Thesis, dissertation, and independent study projects have special significance. Because interests differ among professional associations, multiple presentations and publications may evolve from a single project. There is a fine ethical line, however, between producing relevant professional contributions and reiterating results for the sole purpose of professional recognition. For instance, the author fulfilled the requirements for a masters degree by completing an independent study project focusing on spiritual health as a component of worksite health promotion. At the time, little had been published pertaining to spiritual health, especially within the context of worksite health promotion. Being a topic of interest to a variety of different professional populations, a number of appropriate contributions resulted from this project--specifically, one national presentation, two national poster presentations, two literature review journal articles, and one research-based journal article.

A final avenue for professional writing includes contributing to a text. A graduate student whose work contributes to the profession may be requested to author or co-author a chapter in a text. These opportunities are very few and usually arise only when the student's mentor is in the process of writing or editing a text, invites the student to write a chapter, or recommends the student's work to a colleague planning to edit a text or monograph.

Entrepreneurial Activities

A final avenue for professional contributions consists of assignments and projects that a student can produce and sell as products or services. The student who is creative, energetic, and a risk taker may be interested in producing and selling materials and services for profit. Completed assignments and projects that incorporate state-of-the-art concepts and innovative approaches could be marketed to many different organizations, groups, or individuals. A student with advanced skills in desk top publishing

could feasibly develop a publishing company and sell products that were developed as part of an assignment or project. An innovative behavior change program that was designed and tested as a graduate project could be marketed to worksites or the community as a whole. Compilations of teaching methods could be marketed to either community or school health educators. The list is virtually endless.

Final Considerations

As previously identified, many opportunities exist for graduate students to contribute to the profession. Transforming course assignments and program projects into professional materials benefits both the student's career and the profession. Graduate students should proceed with this process considering the following: 1) Transformation of assignments and projects may be both difficult and time consuming; 2) the scope of some assignments and projects may not be relevant enough to pursue as a contribution; 3) the scope of assignments and projects must coincide with the student's professional interests. A "passion" must exist if the student is to continue to contribute in the future; 4) it is better to produce one professional contribution of high caliber than adopt the "least publishable unit" approach of presenting and publishing over and over small segments of a single project; and 5) the student mentor and other graduate faculty have the experience necessary to assist the student in selecting topics that sell, designing and evaluating projects, and transforming projects to quality professional contributions.

References

Bensley, L. B., Jr. (1990, May 11). Entering the 90's: Health education in the new decade and beyond. Paper presented at the O. N. Hunter Distinguished Scholar Lecture, The University of Utah, Salt Lake City, UT.

Butler, J. T. (1994). *Principles of health education and health promotion*. Englewood, CO: Morton.

Breckon, D. J., Harvey, J. R., & Lancaster, R. B. (1994). *Community health education: Settings, roles, and skills for the 21st century*. (3rd ed.). Gaithersburg, MD: Aspen.

Sechrist, W., & Governali, J. (1990). Selected periodicals for professional health educators. *Health Education, 21*(6), 40-43.

CHAPTER 13

GRADUATE PROGRAMS IN THE YEAR 2020

Glenn E. Richardson, Ph.D.

"I confess that in 1901, I said to my brother Orville that man would not fly for 50 years. . . Ever since, I have distrusted myself and avoided all predictions" - Wilber Wright, 1908

With Wilber Wright's thoughts ringing in my ears and with the same distrust, I sat down to write this article with my head spinning with all the possibilities that await us as a profession and graduate study in the year 2020. Imaginations of futuristic societies, much like those portrayed in popular movies, rushed to my head. As I pondered these scenarios and what really might be in a few years, I realized that a futuristic projection at this time is extremely important for the health education profession. It is not just a guess as to what we will be doing to satisfy curiosity, but rather a critical directional statement to assure our professional survival. I could see two scenarios for our profession--one of prosperity, growth and valuing and the other an elimination.

It seemed too unreal to imagine health promotion efforts with a "Back to the Future" or "Star Trek" mind set, so to ground my projections in some reality, I reflected upon the state of the profession in the early 1970s to see what kinds of advances were made during that quarter century. Assessing advancements in that

quarter century, and factoring in the information and technological explosion we are currently experiencing, would be a help for making projections. Also, if we were to look to the future through the eyes of others, it would help to see where health educators fit in the futuristic scenarios. When we understand our role, then we will be able to characterize graduate education. Graduate education is a major force in the directioning of our profession.

Reflections of Where We Were a Quarter of a Century Ago

We were in a war that divided the nation. Most of us were torn between patriotism and anguish over sending our young people to fight a most difficult jungle conflict. The cold war, the Berlin Wall, the Bamboo Curtain, and the Iron Curtain separated people because of political and cultural diversity.

The hippie movement was referred to as the love generation yet endorsed a rebellion against "the establishment." In the wake of this "if it feels good, do it" era, there was a dramatic rise in the open use of substances such as marijuana, LSD, heroin, methamphetamine (speed runs), and PCP. Alcohol and tobacco use continued to be prevalent among most groups. The "free love" movement showed an increase in the number of cases of "venereal diseases," mainly syphilis and gonorrhea.

We were in the beginning years of making a nation more sensitive to the worth of the environment and individuals regardless of race, gender, or culture. We were becoming alarmed and sensitive to environmental issues and began annual "earth day" celebrations. The peaceful resistance philosophies endorsed by the women's liberation movement, the civil rights movement, and anti war protests often were compromised with violence. We were shocked to witness university students who were expressing their right of free speech, being gunned down by their own national guard. The world was still reeling from the assassination of a popular President, his brother, and a beloved civil rights leader. We were soon to see a President resign in disgrace as a result of a break-in at the Watergate Hotel. The race riots in some of the

great urban centers accentuated the emergence of violence as a social ill.

The technological boom was in full play. We had just witnessed an American making "one small step for man and a giant leap for mankind." Computers that filled rooms were programmed with hundreds of cards, yet only had the capability of today's hand held calculator.

A review of the health textbooks revealed a physiological approach to health education. The cellular basis for life, heredity, the heart and blood vessels, the respiratory system, digestion, reproductive systems, marriage and parenthood, the nervous system, the endocrine glands, the blood, the bones, muscles, fitness, skin, kidneys, nutrition, tobacco, alcohol, drugs, origin of personality, puberty, young adulthood, mental mechanisms, mental illness, and communicable disease were primary health education topics (Guild, Fuisz, and Bojar, 1969). We taught hygiene. Halbert Dunn (1972) had just recently introduced the term wellness to our vocabularies but our approach to health education was still a cognitive approach providing information and using scare tactics (if you smoke, you'll get lung cancer).

Futuristic Indicators From the Last Quarter Century

Some of the important lessons we have learned over the last few years that will carry us into the year 2020 include some of the following:

- There is great worth in all individuals. Gender, race, and culture should have no bearing on the judgment of competence, potential, or intentions of people. Most of us have embraced a dream from 1968 when Martin Luther King (Wells, 1993) said that people should be judged according to the content of their character rather than the color of their skin (and we might add his or her gender or sexual orientation).

- Similarly, people are unique. We all have natural gifts, talents, limitations, and interests. We are learning to accept people regardless of attire, interests, and lifestyles as long as it doesn't infringe upon the rights of others.

- People all over the world will continue to fight until they have democratic and capitalistic societies. The human spirit will not allow repression, rule without voice, or little hope for the future. At the same time, we have learned about the futility of war.

- There may be a price for technological advances. Our illicit drugs are more potent and addicting, pornography is available though many mediums, weapons of war are more destructive, and the ability to keep current in the arenas of education and technology is overwhelming and stressful to many.

- It is important for us to protect our valuable environmental resources.

- We need to be prepared for new challenges. Who would have expected anything as devastating as the AIDS virus?

- We have learned that information coupled with scare tactics are not effective health education strategies for the general population. Yet we still find ourselves doing health risk appraisals, studying risk factors and doing risk reduction programs. Even though the wellness movement began during this last quarter century, the lack of sophistication of intervention to strengthen mind, body, spirit, and social networks is still in its infancy, but we will see it's maturation in 2020.

- We have vacillated from personal intervention strategies to community approaches and now realize that we need both

to be successful and there needs to be an element of "human spirit" to be effective.

- We have developed competencies for health educators as process facilitators and developed a certification program.

In summary, I don't think that we have learned that much compared to other professional fields.

Futuristic Projections for the Next Quarter Century

Futuristic predictions of the world in 2020 range from an absolute "doom and gloom" scenario to one of optimism and hope. The "doom and gloom" futurists based their projections on normal growth curves that occur with all animals and when a certain population is reached, then we start a downward curve toward destruction. These futurists believe that we will ultimately pollute ourselves to death, deplete our ozone protection, and overcrowd to create diseases we have not heard of, to destroy not only our own species but others with us. They also project that the overcrowding and food shortages will create increased violence and hunger. Our own "doom and gloom" professionals are predicting an elimination of the profession. They cite the elimination of health education programs in the community as well as at many university professional preparation programs. The only way that the "doom and gloom" scenarios will occur is if we continue only to react to problems. Proactivity will bring about an optimistic future.

The optimistic component of this scenario is confidence in human ingenuity that will enable us to solve many of our problems. We are developing rapidly in technology, information, communication, and cultural sensitivity which will enable us to have a great deal of control over our futures. We are entering what many futurists call the third wave--the advanced society. The first wave was an agricultural society. The second wave was the industrial revolution where many of our laws, politics, and organizational structures are currently stagnated. The third wave is the adoption

of the educational/technological society. What is fascinating about these waves that reflect a history of the earth's development is that some societies have fixated in a wave.

In the year 2020, we will see societies that embody each of the three waves. In what we have called developing nations, there is still a "hunter-gatherer" and agricultural base. The developed countries are grounded in the industrial society mentality. The most developed countries such as the U.S.A., England, Japan, and Germany will have evolved as third wave leaders. We will have on the planet three classes of countries in the year 2020: the advanced educational/technological societies, the industrial societies, and the agricultural societies. Many will debate whether the third wave provides the best quality of life or perhaps the first wave is still the best. Leaving that discussion behind, much of this article will focus on the future of the educational/technological societies since we will be part of that movement. It is important to remember in this discussion that developing countries and industrial countries will be a large part of the world society. It may be that the future of health education may rest, to some degree, within these societies.

One of the great advantages of the agricultural societies was the interdependence of nuclear and extended family. The industrial society took everyone away from the home: parents to centralized offices, children to schools, elderly to nursing homes, the sick to hospitals, and entertainment was at the local theater. The advanced society will bring the family back as the primary and most powerful social unit of the country. The parents will be able to work out of home offices with advanced technology and communications, the children will be schooled at home through distance learning and numerous educational and experiential programs, home entertainment centers will reduce the need to go out as much, the elderly will be more vital and no longer have to go to a nursing home as early (physician assisted suicide will be common among the elderly), and the sick will be able to do more at home through on-line medical testing and diagnosis (Tofler and Tofler, 1995). This is not to suggest that we will not need time alone and outside romance time as parents.

Education will focus on loving to learn--the process of learning. We will need to inform our students that the information is only good for a couple of years. Being constantly engaged in learning should become a "rush" for students. Cooper and Henderson (1995) have suggested that education will need to be restructured in the electronic/ecological era. The purpose of schools will be to "teach people to learn and to love learning throughout their lives." They see the school as a "collaborative learning community engaged with the larger world." The view of students is one of "explorers and constructors of knowledge both as producers and consumers." The teacher role will be as "facilitators and coaches." Administrators are viewed as "resource brokers and links to the community."

To help us jump our thinking a quarter of a century ahead, consider some of the possibilities that may be evident in our advanced society in Figure 1.

Figure 1: Possible Scenarios for the Year 2020

Some of the ideas were taken from (Coates, 1995)

Genetic Engineering:

- Through the manipulation of genes, we will eradicate many of the known diseases. We will know their genetic linkages and the intermediate chemical processes that lead to the expression of the disease.

- We will see increased longevity and vitality into the mid-eighties. We will be able to genetically fortify target populations (elderly and genetically as-risk populations).

- We will understand the genetic basis of human behavior. The potential for memory enhancement, emotional control, increased learning, sensory acuity, and acquisition of other psychological characteristics will be known.

- Genetic screening and counseling will become an extremely valuable service.

Medicine

- We will see new diseases emerge that we did not know existed.

- Medical practice will treat all dimensions of the patient including mental medicine, physical medicine, spiritual medicine, and social supportive medicine.

The World Culture and Population

- The world population will continue to increase to about 8.4 billion people by the year 2020. Most of the increase will come from the agricultural societies and, to some degree, from the industrial societies. The advanced societies will maintain stable population numbers.

* The world's languages and cultures will become endangered species in the advanced societies. English will be the primary language in international business, science, technology, and entertainment.

- All industrial and educational/technological countries will be capitalistic and democratic. We will see the collapse of the bamboo curtain as we have seen the fall of the Berlin Wall and the Iron Curtain. We will continue to see problems from the developing countries.

- The percentage of elderly will continue to increase but they will also be more productive and work longer. The baby boomers will be in their early 70s and still going strong.

- There will be a world wide popular culture that capitalizes on magnificent communication and entertainment networks.

- There will be a collision of individual human rights, cultural human diversity, and global human opportunity resulting ultimately in a unification and sense of equality among cultures. With this equity there will be pride in cultural heritage at the emotional level. Intercultural marriages will be more frequent and races will become increasingly mixed.

Ecology

- The environment will be managed at global levels. Everything will be smart, that is, responsive to its external or internal environment. This will be achieved through embedding microprocessors and sensors in physical structures throughout the world.

- There will be problems associated with overcrowding. The industrial societies will continue to pollute. We will see the emergence of new kinds of diseases associated with pollution levels. The NIMBY (not in my back yard) conflicts will continue as we attempt to dispose of hazardous materials and house refugees from first wave countries.

- Many natural disasters such as floods, earthquakes, landslides, and so forth will be accurately predicted, managed, controlled, or even prevented.

  Recycling, reclamation, and remanufacturing will be routine.

Technology

- The technology and information gap will continue to widen between first wave societies and the third wave societies. It will also occur within the advanced society as some tire of keeping up.

- Cars will not use gasoline but some alternative source such as solar power.

- Civilian aerospace vehicles will carry travelers half way around the world in 2 hours.

- Home technological/educational/entertainment centers that will be linked into a world wide fiber optic network will have the ability to link any two people on the earth with face to face, voice to voice, and data to data communications.

- We will learn many skills at home through advanced virtual reality training. We will learn to drive, play musical instruments, learn athletic skills, recreate, and learn professional skills in a simulated fashion at home.

- Virtual reality technologies will also be common place for product design and planning. We will be able to put variables together and see the outcomes in a simulated scenario.

- There will be synthetic and genetically manipulated foods to match each individual consumer's taste, nutritional needs, and medical status (i.e. french fries with artificial salt, low cholesterol, and cancer preventive chemicals). Foods will be more diverse as a result of agricultural genetics.

- Farmers will use synthetic soils.

- There will be routine genetic programs for enhancing animals used for food production, recreation, and even pets.

- Custom designed drugs such as hormones and neurotransmitter will be as safe and effective as the naturally produced drugs.

- Robots and other automated machinery will be common place inside and outside the factory, under the sea, in space, mining, and the home.

- Instant language translation of voice to voice and written communication will help shrink the world.

- Computers will learn to learn: programs that will make them smarter and smarter.

- There will be interactive vehicles on highway systems that will prevent many accidents.

- Birth control technologies will be refined and improved.

Education

- Educational systems will be completely restructured: more experiential, personalized, and competency based.

- Schools will become decentralized. More students will be schooled at home for academic classes through distance learning, virtual reality, and other interactive, multidimensional educational programs. The school building will be for experiential, extracurricular, and social purposes.

Issues

- The baby boomers will have seen the fall of Social Security system and will continue to be in the workforce while the government struggles to set up a new system to care for the older populations.

- The educational/technological countries will experience a major financial collapse (another depression) due to the uncontrollable national debt in the U.S.A., the burst of Japan's economic bubble, and Germany's unemployment problems. Emerging from this depression, we will transform ourselves from the industrial era to the advanced era. There will be global currency and international identification cards.

- World unrest, terrorism, and violence will continue: the United Nations will focus more on peace making rather than forceful peace keeping. There will continue to be famine, epidemics, and hardships in developing countries and in some industrial countries.

- "Cyber yuppies" will be the new entrepreneurial elite. There will also be more white collar crime with computers.

Lifestyle

- There will be less animal protein in diets and more vegetarians.

- From home centers we will file taxes (reformed tax system), televote, teleshop, participate in community surveys, access any type of information, and access a wide variety of entertainment. We'll go in cyberspace and other places for simulated virtual encounters.

- Factory manufactured homes will be the norm--metal and synthetic products will be used. Wood will be a luxury.

- Identification cards will be international--multinational business will be the big business form.

- There will be national and universal health care system.

- We will have more recreation and leisure time.

- More focus on religion--both traditional and "New Age" type of secular humanism because of the need for high touch.

- Quality, service, and reliability will be routine business criteria around the globe. Customized products will be the norm.

Health Education in 2020

How do we fit in a futuristic society and learn from the lessons of the past? We will have seen the introduction of the third wave during the 1990s--the transformation decade.

Perhaps a typical scenario for a health educator in 2020 would be to begin our working day with a conference with the people we work with, all of whom are at their homes. Our health team is a multidisciplinary team made up of psychologists, social workers, physicians, sociologists, and medical professionals. There had been such an emerging of the professions that we had to begin to work together and pool our expertise. The health educator is the facilitator.

Our large screen with incredible clarity has the face of each co-worker live and in color from each of their individual homes. We discuss what needs to be accomplished during the day. Some of the following might represent some agenda items for the meeting.

- One person is assigned to fly to Africa for an 11:00 meeting to meet with some health educators who are doing health education much like was done back in 1996. These nations are still an agricultural society and have become the hot bed for traditional health education with high tech interventions.

- Someone will need to meet with the media people today as a process expert for a production of a new virtual reality program. This program is for young people to help them become productive citizens. The program will put them in situations where they will be able to identify their gifts and talents. They will be asked to do several skills using their talents. The program will help them discover their dream. The causes in society will be portrayed in a multisensory way. Emotional/spiritual responses will be recorded with advanced biofeedback equipment. Emotional, mental, and physical responses will record anxiety, excitement, peace, and spiritual motivation to engage in any of the causes. Subsequent programs will provide simulated experiential opportunities to refine the skills associated with the cause as a precursor to actual immersion into the cause.

- Another professional will be assigned to a "high touch" intervention group. They are preparing family programs for home or for family retreats at recreational resorts. With all the high technology, we have learned that people long for human understanding and caring. Family programs are the most important and popular intervention program. Families, from the privacy of their homes, will go through spiritual and family experiences of touch, caring, trusting, loving, moral framework development, family causes, identification of family strengths, and heart to heart communications.

- Since most basic education for young people occurs at home, the public schools and non-university schools of higher education have been converted into community education centers. The public schools still serve the social needs of the students but time at school is limited. The universities are more focused on research but have strong links with these community centers. One person on the community health coalition is assigned to upgrade the

experiential education programs at the community education center. The school caters mostly to adults whose jobs have been eliminated due to the rapidly changing world. It seems that jobs are eliminated overnight. Health education careers can be developed for those who like to travel. Many of the industrial countries and all of the agricultural countries need people to help them with basic health practices. We have health educators helping to train these people.

- One of the most controversial interventions is genetic manipulation to help people become stronger, live longer with more energy, modify personalities, assign gender to a child, and remove genetic tendencies for numerous diseases. The moral implications will still be debated, yet genetic counselors (health educators) will need to be informed and be able to deal with the physical, mental, social, and spiritual dimensions of genetic choices. At the community education center, we are constantly updating new interventions and one person is assigned to communicate with the genetics research facilities for an update. Appropriate data transfers will occur instantly.

Graduate Programs in 2020

To support the community education centers, the University will continue to do research on the best ways for individuals, communities, businesses, and young people to lead healthy lifestyles. We will see a number of changes from the graduate programs of today.

Philosophically, health education graduate programs will have made a shift and abandoned the risk reduction, problems oriented, and information only approaches. Instead the philosophical paradigm will be on identifying, fortifying, and building strengths, gifts, and talents within individuals, families, and communities. We will have become a proactive rather than a reactive

profession. We have become less product oriented but fascinated and skilled with the process of fortifying people. We have put professionalism and science to a redefinition of health. We have skilled interventions to strengthen the mind, the body, and the human spirit. We also have embraced and made tangible systems theory. Interdependent health, inclusive of social and environmental elements, has become an extremely popular type of graduate research.

As we view the health education competencies (National Task Force on the Preparation and Practice of Health Educators, Inc., 1985), we can see that part of what we do is still included except in an advanced way.

- Assessing individual and community needs for Health Education: The competencies are still there but the approaches will be through on-line technologies.

- Planning effective health education programs: The health education programs will rely less on human teaching and more on technology. These will need to be developed for first, second, and third wave societies.

- Working with individuals, groups, and organizations to implement health education programs: The merging of the professions will require this as an extremely important competency. Networking will be key to our survival.

- Evaluate the effectiveness of health education programs: We will be using evaluation tools that bring together numerous variables in portraying group and individual profiles. This will be a vital role for us.

- Coordinating provision of health education services: The team of specialists approach under the direction of a health educators is a role we may still have.

- Act as a resource person in health education: We will need to be very comfortable with accessing health information and education resources. We will need to be at our professional best doing this.

- Communicating health and health education needs, concerns, and resources: The primary networking system to communicate the health needs, concerns and resources will be between the university, community education centers, national health organizations, and local governments (state and city). We will see states become more responsible for programs.

Proactive Graduate Study

There will likely be five areas of graduate study.

- Statistics and research: Most studies will use refined naturalistic inquiry and qualitative data gathering approaches to human research. We will have learned the inaccuracies of standardized biopsychosocialspiritual instruments. We will have learned that the uniqueness of each individual requires personalized, branching, and interactive assessments for data gathering and interpretation. Computer programs much like structural equations modeling and Liseral will be available to put hundreds of variables into a composite profile of the individual. The efficacy of sophisticated personal and interdependent systems interventions will be accurately measured by showing which of the health variables are affected. Similar programs will be available that will make profiles of a community. We will have provided some sophistication to strength assessments.

- Languages/Cultural Understanding: Most of the demand for graduate students will be in agricultural communities

and industrial societies. Native languages will still be prevalent in these societies. Graduate students will be required to speak and write fluently in at least two international languages. One will be required in an agricultural society such as an African language and the other will be in an industrial society language such as Spanish. Virtual reality booths on campus will immerse the students into the culture for hours at a time. Students will be able to be fluent within a few intensive weeks.

- Technology: Most homes in advanced societies will have access to fiber optic face to face communications, virtual reality programs, and all available information at the touch of a button. Consumers will continue to be amazed at the information available on the cyberspace information freeway. It will become important for graduate students to be very familiar with the technology and how to prepare materials and avenues to contribute to those information/simulation systems. Research subjects for students will likely come from volunteers who are on-line with testing, assessments, and evaluations occurring in the subject's home. Programming will not be required of health educators in that technicians will be available to help. Simulation systems will be very important for graduate students to understand. With the capability of seeing behavioral, physical, spiritual, and mental outcomes of hundreds of combined mental, spiritual, and physical variables in a simulation system, students will be able to manipulate the variables to identify ideal intervention programs leading to healthier and happier lifestyles for consumers.

- Health Education Content: Separate courses on alcohol, tobacco, drugs, fitness, stress management, nutrition, and human sexuality will be taught from a systems and strengthening approach. These topics are important only as a variable influence on overall individual or community

profile. We will have evolved beyond working with symptomatic expressions of internal conflict such as the unhealthy behaviors about which we are currently concerned. Health interventions will be to strengthen the mind and human spirit of our consumers so that people will be responsible nutritionally, sexually, physically, and in the use of substances because they will feel how it fortifies their system. Stress will be seen as an opportunity for growth. The content basics of health, in its evolution, will be common knowledge in the world, for the most part, but individualized and interactive learning programs will assure competence. We will have a course on ecological health which again will be a systems approach on how triggers, both positive and negative, affect the individual, environment, families, and communities. Spiritual health will be a major focus in the year 2020. We will have assessment instruments that will be able to measure spiritual states. Health education with many groups will be the process of facilitating people to identify their spiritual nature and to follow a path with heart. "Touchy feely" of the 1970s will be professionalized and become the scientific (measurable) "touchy feely" of 2020. With international communication at the touch of a button, we will align the ancient Eastern philosophies of the Tao and others with modern science. This will be particularly important with family programs that promote love, trust, caring, and nurturing.

Most of the graduate curriculum will be on process. Topics such as the following will be critical (Richardson, 1995).

- Understanding the process of growth, coping, and resilient living (value of disruption and reintegration).

- Understanding the interaction and interdependence of mind, body, and spirit in a personal and the ecological sense.

- Facilitating the discovery of human potential: a mind, body, and human spirit paradigm. Applications will be both personal and ecological.

- The generation of human energy.

- Paradigms and processes for resilient living: living within moral frameworks, the wise utilization of human energy, seizing the day, and law of the harvest.

- The creative process is forming personal dreams and common causes.

- Skills of the mind, body, human spirit, and ecological interventions will be effective and specific to unique populations.

- The process of what Maslow called "transcendence" or a transformation to rise above circumstances will be applied to individuals and ecosystems.

- Develop skills necessary to be expert planners, organizers, facilitators, evaluators, and leaders. The approach will not be "here's how you do it" but rather a facilitation of discovering the organizer, planner, evaluator, and leader within individual archetypes.

- We will be experts at accessing health information in the new technologies.

Graduate Study Projects

Graduate students will use virtual technologies and computer programs that have actually learned to learn. Students still will be fascinated with personal and community behavior change.

At the personal level, graduate students will experiment with triggers that affect the entire body as well as the interdependent ecology. A spiritual trigger, such as watching a humanistic, selfless, and caring act for someone in an agricultural society, will be measured with sophisticated biofeedback sensors to determine effects on systems of the body and the mind. The intent will be to create optimal states of happiness and health. We will identify resiliency triggers for people who are upset, feel guilty, or feel hurt.

In families and communities, the human and ecological systems will be studied to see how one element will affect other parts of the ecology. We will become skilled at creating triggers for families, businesses, and communities to rally around a cause and work together for that cause. The key to this will be assessing and understanding the positive nature of the individuals and within the interdependent populations we will be serving.

A Challenge to the Profession

Whether our world is on the threshold of a Golden Age or on the brink of a global cataclysm that will extinguish our civilization is, not only unknowable, but undecided. The decision will emerge though what we, as a society, do in the years ahead. For health educators, our destiny rests with our ability to capitalize upon the efficiency that comes from high tech and also skill ourselves in the business of high touch to facilitate health and happiness in the clientele and communities we serve. We will need to be very good at what we do or we may be eliminated. Whether our profession will be phased out or not depends upon our initiative. If we can be proactive and see the trends, then we may find ourselves in professional scenarios cited above or something similar. If we can see that the self help movement, the increasing home technology, the crying for high touch spiritual fulfillment, and the late 1990s and the early part of the next millennium as a transformation time for

the profession, then our universities and graduate programs will have a vital role in peace, contentment, health, and happiness of the people in the year 2020.

References

Bailey, R. (1995, Jan/Feb). Seven doomsday myths about the environment. *The Futurist,* 14-17.

Cooper, C. & Henderson, N. (1995). *Motivating Schools to Change: Integrating the Threads of School Restructuring.* Global Learning Communities, Tasmania.

Coates, J.F. (1995). Science and technology in the year 2025. *The Futurist*, 14-17.

Dunn, H. (1972) *High Level Wellness.* (7th ed.). Arlington, VA: R.W. Beatty Co.

Guild, W.R., Fuisz, R.E., & Bojar, S. (1969). *The Science of Health.* Englewood Cliffs, NJ: Prentice Hall, Inc.

Cleveland, H. (1995, March/April). The limits to cultural diversity. *The Futurist*, 23-26.

National Task Force on the Preparation and Practice of Health Educators, Inc. (1985). *A framework for the development of competency-based curricula for entry level health educators*, New York: Author.

Richardson, G.E. (1995). *The Resiliency Training Manual.* Madison: Brown and Benchmark.

Snider, J.H. (1995, March/April). The information superhighway as environmental menage. *The Futurist*, 16-21.

Toffler, A. and Toffler, H. (1995, March/April). Getting set for the coming millennium. *The Futurist,* 10-15.

Wells, D. (1993). *We have a Dream.* NY: Carolyn Grant Publisher.

CONTRIBUTORS

Association for the Advancement of Health Education, Society for Public Health Education, Joint Committee for the Development of Graduate Level Preparation Standards, 1900 Association Drive, Reston, VA 22091

Evelyn Ames Ph.D., CHES, Emeritus Professor of Health Education, Physical Education, and Recreation, Western Washington University, Bellingham, WA 98225

Robert J. Bensley, Ph.D., Assistant Professor, HPER Department, Western Michigan University, Kalamazoo, MI 49008

Jodi Brookins-Fisher, MS Teaching Assistant, Department of Health Education, University of Utah, Salt Lake City, UT 84112

William B. Cissell, Ph.D., M.S.P.H., CHES, Professor and Chair, Department of Health Studies, Texas Woman's University, Denton, TX 76203-3499

William H. Creswell, Ed.D., Emeritus Professor of Health Education, University of Illinois, Urbana-Champaign, Champaign, IL 61821

Judy C. Drolet, Ph.D., CHES, FASHA, Professor of Health Education, Southern Illinois University, Carbondale, IL 62901-4632

Joyce V. Fetro, Ph.D., CHES, FASHA, Supervisor of Health Programs, San Francisco Unified School District, San Francisco, CA 94115

Onie Grosshans, H.S.D., M.P.H., CHES, Associate Professor and Chair, Department of Health Education, University of Utah, Salt Lake City, UT 84112

Teresa Pennington Hardman, Ph.D., Assistant Professor, Department of Health, Physical Education, and Recreation, Morehead State University, Morehead, KY 40351

CONTRIBUTORS

Alan C. Henderson, Dr.PH, CHES, Professor, Health Science Department, California State University, Long Beach, CA 90840-4902

James Neutens, Ph.D., Professor, Director of Education, OBGy ., University of Tennessee Medical Center, The University of Tennessee, Knoxville, TN 37920-6999

Ann E. Nolte, Ph.D., Emeritus Professor of Health Education, Illinois State University, Normal, IL 61761-6901

Sheila M. Patterson, Ph.D., CHES, Chairperson, Department of Health, West Chester University, West Chester, PA 19383

Glenn E. Richardson, Ph.D., CHES, Professor, Department of Health Education, University of Utah, Salt Lake City, UT 84112

Mohammad R. Torabi, Ph.D., M.P.H., CHES, Professor, Assistant Chairperson and Coordinator of Graduate Studies, Department of Applied Health Science, Indiana University, Bloomington, IN 47405

Kathleen Welshimer, Ph.D., M.S.P.H., Associate Professor, Health Education and Recreation, Southern Illinois University, Carbondale, IL 62901